

Infant Feeding/Napping Schedule

Name of Child: _____ Age _____

Arrival Time: _____

Feedings:

(Formula, Breast milk) circle one or both please

First Feeding	Second Feeding	Third Feeding	Fourth Feeding
Time Amt	Time Amt	Time Amt	Time Amt

Solids:

Time Amt	Time Amt	Time Amt	Time Amt
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Special Instructions for bottle feedings: _____

What shall we do with uneaten bottles or solids? _____

Bedding will be supplied by Parents and returned home for laundering weekly. Children will be supplied with a crib and a quiet place to sleep under supervision of staff. Cribs will be a minimum of 2 ft apart when in use.

Napping: (time/amount of)

First Nap	Second Nap	Third Nap
Time Amt	Time Amt	Time Amt

Special instructions for napping: Babies sleep on back unless medical reason not to.

Does he/she need a pacifier? _____
sleep sack (preferred)? (Blankets are not allowed)

Other? _____

Other important information: _____

Departure Time: _____

Parent Signature: _____

Print Parent Name: _____

Provider Signature: _____

Date: _____