



Infant Habit Sheet

Child's Name: _____ Child's Age: _____

Amount in Bottles: Breastmilk? Formula? Brand:	Approximate Feeding Times:
Foods Child is Eating (if any): 	Approximate Feeding Times:
Nap Schedule: 	Known Allergies (if any):

NOTE: Please bring in one more bottle than you anticipate your child will use to accommodate any spills!