INFANT MENU 4-7 MONTHS

Prov/Cent Name________________________________ Infant Name_______________________________ DOB_______________________

House Formula____________________

TO BE COMPLETED BY PARENT

HOUSE FORMULA: Accept____ Decline_____ Parent's Formula Choice____________________ Breast Milk ______

Provider provides food ______ Parent provides food ______

CIRCLE THOSE FOODS YOU WOULD ALLOW US TO SERVE YOUR CHILD:

CEREAL: RICE OATMEAL BARLEY OTHER__________________

FRUIT: APPLESAUCE BANANAS PEACHES PEARS PRUNES OTHER_________________

VEG: CARROTS GREEN BEANS SWEET POTATOES SQUASH PEAS OTHER________________

Parent's Signature_____________________________________ Date_______________________

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
LUNCH/SUPPER	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
	0-3 T FRUIT OR VEG.					
AM/PM SNACK	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK

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