

DAILY SCHEDULE FOR YOUR INFANT

Please tell us a little about your child.

Child's Name: _____

Nicknames: _____

Age: _____ Birth date: _____

Please Check One:

Formula Breast Milk

Both / Formula Backup if on Breast milk

Child's Regular Eating Schedule: _____ ounces every _____ hrs.

How do you get your child to sleep? _____

How do you comfort your child? _____

Would you like your child to have a sleep sac at naptime, parent provides? Sleep Sac

Please list any other comments that you feel would be helpful to us...

Parent Signature: _____ Date: _____