



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION AND CHILDE AND ADULT CARE FOOD PROGRAM  
**INFANT AND TODDLER FEEDING AND CARE PLAN**

**THIS SECTION TO BE COMPLETED BY CHILD CARE FACILITY:**

The formula provided by this child care facility is: \_\_\_\_\_.

**(Check a box)**  Yes  No This child care facility **is participating** in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

**Instructions to Parents** - Please complete for child who is less than 24 months of age. *Update information as needed. Use a new for or initial/date changes on this form.*

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED
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**FEEDING INFORMATION**

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
Formula			
Infant Food			
Table Food			

Who is preparing (mixing) the formula? Check all that apply:  Parent  Caregiver

Does your child have any problems with feedings, such as choking or spitting up?

Yes Explain: \_\_\_\_\_  
 No

Does your child use a pacifier?  Yes  No

**Note:** Pacifiers, if used, cannot be hung around an infant's neck. Pacifier mechanisms or pacifiers that attach to infant clothing cannot be used with sleeping infants.

**INFANT FEEDING PREFERENCE (under 12 months)**

Mark your preference (check all that apply).

- I will provide breast milk for my infant.
- I will nurse my infant at the center at these times: \_\_\_\_\_

The facility's formula may be used to supplement feedings if necessary:  Yes  No

If breast milk is unavailable for a feeding, the facility should: \_\_\_\_\_

- I request that the formula provided by the child care facility be served to my infant
- I will provide infant formula for my infant. Name of formula: \_\_\_\_\_
- I request that the child care facility provide solid foods for my infant as s/he is ready for them, and after I have discussed it with child care facility staff. **OR**
- I will provide solid foods for my infant.

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**TODDLER FEEDING PREFERENCE (12 through 23 months)**

Check all that apply:  Spoon  Cup  Feeds Self  Feeding Table or Chair

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breast Milk			
Milk			
Table Food			

**ARRANGEMENTS FOR SLEEP – Licensing rules require that infants be placed on their back to sleep.**

TIME(S) CHILD USUALLY NAPS	LENGTH OF NAP
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**Additional Instructions Related to Sleeping:**

**Note:** When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements that differ from those required by rule, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements for such infant. The caregiver(s) must put the infant to sleep in accordance with such written instructions.

My child is 12 months or older, and I give my permission for my child to sleep on a cot.

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE
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**DIAPERING INSTRUCTIONS**

LIST ANY LOTIONS AND/OR OINTMENTS, ETC. THAT YOU HAVE PROVIDED AND GIVE PERMISSION FOR CAREGIVERS TO USE ON YOUR CHILD

FOR  WET  BOWEL MOVEMENT  RASH  OTHER

I do not want caregivers to use any lotions, powders, ointments or similar items on my child.

I WILL FURNISH THE FOLLOWING BABY SUPPLIES FOR MY CHILD; CLEARLY LABELED WITH MY CHILD'S NAME

SPECIAL INSTRUCTIONS FOR CARE (E.G., RESTRICTIONS, ALLERGIES, ETC.):

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE
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