HEALTH CONSULTANTS FOR CHILD CARE

INFANT DIETARY INSTRUCTION FORM

Child's Name: _____ **Date of Birth:** _____

All foods must be tried at home for 3 – 5 days to observe for allergic reactions.
Please initial and date next to each food to be given at the center.
For combination foods, be sure to sign off on all ingredients. *All food must be in non-chokable size.*

	Initials	Date
PROTEINS:		
Beef		
Cheese		
Chicken		
Cottage Cheese		
Ham		
Turkey		
Tofu		
Yogurt		
FRUITS:		
Apple		
Apricot		
Banana		
Blueberry		
Blackberry		
Cherries (pitted)		
Kiwi		
Mango		
Melons		
Papaya		
Pears		
Plums		
Prunes		
Raspberry		
Strawberry		

	Initials	Date
VEGETABLES:		
Avocado		
Beans		
Beets		
Broccoli		
Carrots		
Celery		
Corn		
Cucumber		
Garbanzo		
Green Beans		
Jicama		
Kale		
Lentil		
Peas		
Potato		
Pumpkin		
Spinach		
Squash		
Yam		
Zucchini		
GRAINS:		
Barley		
Oatmeal		
Quinoa		
Rice		
Wheat		

Please check all that apply:

Breast Milk ___Formula ___ Whole Milk ___Soy Milk __ Selected Items-Program Menu _____

I have tried the above foods and give permission for them to be given to my child.
I understand that this list is not inclusive; therefore I give permission for any foods/combinations of foods brought in from home to be given as well.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date