Child's Name:_____ **Infant Daily Routine 0 – 7 Months**

Morning feeding time at school:

AM Bottle: Time :_____ Amount: _____

AM Nap: Time: _____ Approx. Length of nap: _____

AM Food: Time :_____ What: _____

Lunch feeding time at school:

Bottle: Time:_____ Amount:_____

Nap: Time:_____ Approx. Length of nap:_____

Food: Time:_____ What: _____

Afternoon feeding time at school:

PM Bottle: Time:_____ Amount:_____

PM Nap: Time:_____ Approx. Length of nap:_____

PM Food: Time:_____ What: _____

Are you trying cereal or baby food with your child yet? _____

Is your child:

A thumb sucker ☐ _____ Needs a pacifier ☐ _____

Rolling over ☐ _____ Sits up by themselves ☐ _____

Plays in the jumper ☐ _____

Parent signature: _____ Date: _____