MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

PARENT'S SPECIALIZED INSTRUCTIONS FOR INFANTS AND TODDLERS

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED

INSTRUCTIONS TO PARENTS

- Please complete for child who is less than 24 months of age.
- Update diet information as needed until child is on complete table food. Use a new form or initial/date changes on this form.

FEEDING METHOD

CHECK ALL THAT APPLY

☐ SPOON ☐ CUP ☐ BOTTLE ☐ WARM BOTTLE ☐ HOLDS OWN BOTTLE ☐ FEEDS SELF ☐ FEEDING TABLE OR CHAIR

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
FORMULA OR BREASTMILK			
WHOLE MILK			
INFANT FOOD			
JUNIOR FOOD			
TABLE FOOD			

ARRANGEMENTS FOR SLEEP – Licensing rules require that infants be placed in a crib, on their back, to sleep.

TIME CHILD USUALLY NAPS	USUAL LENGTH OF NAP

SPECIAL NEEDS/INSTRUCTIONS RELATED TO SLEEPING

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

PARENT'S SIGNATURE	DATE

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 (RESTRICTIONS, ALLERGIES, ETC.)

PARENT/LEGAL GUARDIAN SIGNATURE	DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

INFANT FEEDING PREFERENCE

Name of Infant _____ Date of Birth_____

The child care center will feed your infant: breastmilk provided by you; formula provided by you; or the following iron fortified formula purchased by the center _____

Please mark your preference (choose all that apply)	Date_____ **Birth thru 3 months**	Date_____ **4 thru 7 months**	Date_____ **8 thru 11 months**
I will provide expressed breastmilk for my infant.	☐	☐	☐
I will breastfeed my infant at the center.	☐	☐	☐
I want the center to provide formula for my infant.	☐	☐	☐
I will purchase/provide the following brand of formula for my infant: _____	☐	☐	☐

This center is participating in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the center must provide (purchase) infant cereal and other solid foods when your baby is developmentally ready according to the *Food Chart - Infants*.

Please mark your preference	Date_____ **4 – 7 months**	Date_____ **8 – 11 months**
I want the center to provide infant cereal and other foods for my infant based on CACFP guidelines.	☐	☐
I will bring solid food for my infant when he / she is ready for it.	☐	☐

First Signature of Parent / Guardian _____ Date_____

Second Signature of Parent / Guardian _____ Date_____

Third Signature of Parent / Guardian _____ Date_____