



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
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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
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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
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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 (RESTRICTIONS, ALLERGIES, ETC.)

PARENT/LEGAL GUARDIAN SIGNATURE	DATE
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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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I will breastfeed my infant at the center.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I want the center to provide formula for my infant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I will purchase/provide the following brand of formula for my infant: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.	<input type="checkbox"/>	<input type="checkbox"/>
I will bring solid food for my infant when he / she is ready for it.	<input type="checkbox"/>	<input type="checkbox"/>

First Signature of Parent / Guardian _____ Date _____

Second Signature of Parent / Guardian _____ Date _____

Third Signature of Parent / Guardian _____ Date _____

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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).