

INDIVIDUAL INFANT MEAL PATTERN

Month: _____ Year: _____ Formula: _____ PROVIDER: _____

Name: _____ ALLERGY STATEMENT ON FILE? YES ___ NO ___

Age: _____ Date of Birth: _____

Record the component(s) served after each meal. See the infant meal pattern for meal component requirements.

FOOD COMPONENTS	DAY:	DAY:	DAY:	DAY:	DAY:
	DATE:	DATE:	DATE:	DATE:	DATE:
BREAKFAST					
(1) Breast milk* or iron-fortified fluid infant formula					
(2) Infant cereal--dry, iron-fortified					
(3) Fruit and/or vegetable					
AM SUPPLEMENT					
(1) Breast milk* or iron-fortified fluid infant formula or full-strength fruit juice					
(2) Bread or crackers made from whole grain or enriched flour or meal					
LUNCH:					
(1) Breast milk* or iron-fortified fluid infant formula					
(2) Infant cereal--dry, iron-fortified					
(3) Meat or meat alternate: meat, Fish, poultry, egg yolk, cooked dry beans or peas cheese, cottage cheese, cheese food or cheese spread					
(4) Fruit and/or vegetable					
PM SUPPLEMENT:					
(1) Breast milk* or iron-fortified fluid infant formula or full-strength fruit juice					
(2) Bread or crackers made from whole grain or enriched flour or meal					
SUPPER:					
(1) Breast milk* or iron-fortified fluid infant formula					
(2) Infant cereal--dry, iron-fortified					
(3) Meat or meat alternate: meat, Fish, poultry, egg yolk, cooked dry beans or peas cheese, cottage cheese, cheese food or cheese spread					
(4) Fruit and/or vegetable					

*Breast milk, provided by the infant's mother only, is recommended for the first year.