HEALTH CONSULTANTS FOR CHILD CARE INC.

Child's Name _____ Date of Birth _____

Infant Dietary Instruction Form

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.

	initials	date
PROTEINS:		
Beef		
Cheese		
Chicken		
Cottage Ch.		
Ham		
Turkey		
Tofu		
Yogurt		
FRUITS:		
Apple		
Apricot		
Banana		
Blueberry		
Coconut (not raw)		
Kiwi		
Mango		
Peaches		
Pears		
Plums		
Prunes		
Raspberry		
Strawberry		

	initials	date
VEGETABLES:		
Avocado		
Beans		
Broccoli		
Carrots		
Corn		
Garbanzo		
Green Beans		
Kale		
Lentil		
Parsnips		
Peas		
Potato		
Pumpkin		
Spinach		
Squash		
Sweet Potatoes		
Zucchini		
GRAINS:		
Barley		
Oatmeal		
Quinoa		
Rice		

Please check all that apply:

Breast Milk _____ Formula _____ Whole Milk(inc. organic or lactose free) _____ Soy Milk _____

I have tried the above foods and give permission for them to be given to my child.

I understand that this list in 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

1210 MORNINGVIEW DR. ■ MOUND, MN 55364 ■ 952/472-3915

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