

INFANT MENU FORM

Child's Name:	Provider's Name:							
DOB:	Meal Pattern Requirements for Infant			Date	Date	Date	Date	Date
Use meal pattern appropriate to age group. Use foods of app. consistency	Birth through 3 months	4 through 7 months	8 through 11 months	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
BREAKFAST - Breast Milk or Iron-Fortified Infant Formula - Iron-Fortified Infant Cereal - Vegetable and/or Fruit	4-6 Fluid oz. ⁽¹⁾ 0 0	4-8 Fluid oz. ⁽¹⁾ 0-3 Tbsp. ⁽²⁾ 0	6-8 Fluid oz. ⁽¹⁾ 2-4 Tbsp. 1-4 Tbsp	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk
AM SNACK - Breast Milk or Iron-Fortified Infant formula - Whole Grain or Enriched Bread or Cracker-Type Product	4-6 Fluid oz. ⁽¹⁾ 0 0	4-8 Fluid oz. ⁽¹⁾ 0 0	2-4 Fluid oz. ^(1,3) 0-1/2 slice ⁽²⁾ 0-2 Crackers ⁽²⁾	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk
LUNCH -Breast Milk or Iron Fortified Infant Formula -Infant Cereal or Meat/ Alternate -Vegetable and /or Fruit	4-6 Fluid oz. ⁽¹⁾ 0 0 0	4-8 Fluid oz. ⁽¹⁾ 0-3 Tbsp. ⁽²⁾ 0 0-3 Tbsp. ⁽²⁾	6-8 Fluid oz. ⁽¹⁾ 2-4 Tbsp. 1-4 Tbsp. 1-4 Tbsp	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk
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SUPPER - Breast Milk or Iron Fortified Infant Formula - Infant Cereal or Meat / Alternate -Vegetable and/or Fruit	4-6 Fluid oz. ⁽¹⁾ 0 0 0	4-8 Fluid oz. ⁽¹⁾ 0-3 Tbsp. ⁽²⁾ 0 0-3 Tbsp. ⁽²⁾	6-8 Fluid oz. ⁽¹⁾ 2-4 Tbsp. 1-4 Tbsp. 1-4 Tbsp	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk
EVE SNACK - Breast Milk or Iron-Fortified Infant formula - Whole Grain or Enriched Bread or Cracker-Type Product	4-6 Fluid oz. ⁽¹⁾ 0 0	4-8 Fluid oz. ⁽¹⁾ 0 0	2-4 Fluid oz. ^(1,3) 0-1/2 slice ⁽²⁾ 0-2 Crackers ⁽²⁾	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk	<input type="checkbox"/> Formula <input type="checkbox"/> Breast Milk

⁽¹⁾ For some breastfed infants who regularly consume less than the minimum amount of breast milk per feeding, a swerving of less than the minimum amount of breast milk may be offered, with additional breast milk offered if the infant is still hungry.

⁽²⁾ A serving of this component is optional for this age group. For infants receiving solid foods, the provider must supply at least one component of the meal to request reimbursement, either formula or a food item.

⁽³⁾ Full-strength fruit juice may be substituted for breast milk or infant formula at snack for 8-11 months only.

Parent Supplies Solid Foods
 Provider Supplies Solid Foods

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