



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 COMMUNITY FOOD AND NUTRITION ASSISTANCE
 CHILD AND ADULT CARE FOOD PROGRAM
INFANT FEEDING PREFERENCE

Name of infant _____ Date of Birth _____

_____ will feed your infant breastmilk provided by you and / or we
 (name of provider)
 will provide iron fortified infant formula.

The formula we provide is: _____

Please mark your preference (choose all that apply)	Date Birth – 3 months	Date 4 – 7 months	Date 8 – 11 months
I will bring expressed breastmilk for my infant.			
I will come to the center to breastfeed my infant.			
I want the center to provide formula for my infant.			
I will bring formula for my infant. Please list kind of formula you will bring: _____			

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

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 _____

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