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

INFANT FEEDING PREFERENCE – CENTERS

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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