

INFANT MENU 4-7 MONTHS

Provider Name _____ Infant Name _____ DOB _____

DATE						
MEAL	MENU ITEM	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
BREAKFAST	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
	LETTER					
LUNCH/SUPPER	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
	0-3 T FRUIT OR VEG.					
	LETTER					
AM/PM SNACK	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					

DATE						
MEAL	MENU ITEM	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
BREAKFAST	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
	LETTER					
LUNCH/SUPPER	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
	0-3 T FRUIT OR VEG.					
	LETTER					
AM/PM SNACK	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					