

E.3 Infant Food Intake Form

LOGO

OMB Control No: 0584-XXXX
OMB Approval Expiration Date: XX/XX/XXXX

Study on Nutrition and Activity in Child Care Settings (SNACS)

Infant Food Intake

Child Care Center ID

Target Week

Caregiver Initials: | | | |

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0584-XXXX. The time required to complete this information collection is estimated to average 10 minutes per infant (for an estimated total of 50 minutes per infant care provider), including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

About the Study. The Study on Nutrition and Activity in Child Care Settings is intended to study nutrition and activity in child care centers, family day care homes, afterschool programs, and at-risk programs participating in the Child and Adult Care Food Program (CACFP) and some not participating in the CACFP. More than 1,500 child care providers in over 20 states were selected to be part of the study. Abt Associates is conducting this study for the USDA Food and Nutrition Service (FNS).

About this Booklet. This booklet is to be filled out by the infant care provider, and will be used to collect information about the foods and beverages consumed by up to three infants for one day, and the time of each feeding while in the provider's care. This includes foods brought in from home as well as prepared at the center. The infant care provider will receive \$5 for completing the form for each sampled infant.

Protecting Privacy. All information gathered from child care sponsors, child care centers, family day care homes, child care administrators and staff, and families participating in this study is for research purposes only and will be kept private to the full extent allowed by law. Responses will be grouped with those of other study participants, and no individual participants, program administrators, program staff, parents, or children will be identified in any study report.

Questions. If you have any questions about the study please call our toll-free study number at 1-844-808-4777 or email SNACS@abtassoc.com. We will be happy to answer your questions and to help you in any way we can.

Thank you for participating in the Study on Nutrition and Activity in Child Care Settings.

Tab 1

Instructions

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INSTRUCTIONS

Please use this form to record all the foods, drinks, formula, and/or breast milk you served to the infants being observed while he/she is in your child care facility on the day noted on the front cover. **Please be sure to include anything brought in from home by the parent or guardian that was served to the infant.**

USE ONE BOOKLET FOR THREE INFANTS:

One booklet should be used to record the intake of up to **three infants** on **one day**. Each infant care provider will receive one booklet to record information for these three infants.

Write the name of the infant on each separate form, found on **Tabs 4, 5 and 6**.

This booklet contains:

- **TAB 1:** Instructions
- **TAB 2:** Measurement Guide
- **TAB 3:** Example of a completed Infant Intake Form
- **TAB 4:** Infant Intake Form – Infant 1
- **TAB 5:** Infant Intake Form – Infant 2
- **TAB 6:** Infant Intake Form – Infant 3

Each infant should be recorded in a separate tab (space for 3 infants is provided)

HOW TO FILL OUT THIS BOOKLET

Fill out the information at the top of the form: Date, Day of the Week, Infant Name, Infant Birthdate, Age Group of Infant, and Gender. When selecting the age group, keep in mind the age groups are as follows:

- Birth through 3 months
- 4 through 5 months
- 6 through 7 months
- 8 through 11 months

For example, you would circle 6 - 7 months for an infant who is 7.5 months old.

Then follow the instructions at the top of each column:

Time of Feeding

- Write down the time you started each feeding, including a.m. or p.m. This will help you keep track of the feedings you have recorded.

What Did You Serve or Feed (to the Infant)?

- For each feeding, write down everything you fed to the infant, including formula, breast milk, solid foods (including purees and blended/mashed foods), snacks, and any other drinks. Use a separate row for each food or beverage.
- If you serve juice, please indicate if it is 100% juice in the “What did you serve or feed” column. *Please see the last row of the example form.*
- Check the box to indicate whether the food or drink was **brought from home** or **prepared in the center**.
- **Please also list any time the mother comes to the center and nurses the infant being observed** in the center. You can indicate this by selecting the checkbox labeled “mom nursed” in the “What did you serve or feed” column.
 - *Do not worry about recording the amount of breast milk consumed during nursing sessions. Simply write “N/A” for not applicable in the last column. Please see the first row of the example form.*

How Much Did the Infant Eat or Drink?

- Write down how much of each item the sampled infant ate or drank.

If you use standard measuring tools:

- For **liquids** (formula, breast milk, water, juice, whole milk, and any other liquids or drinks), record amount eaten in fluid ounces. Do NOT record liquids in numbers of cups. For example, write “4 fl. oz.” NOT “1/2 cup”
- For foods, use standard measures such as “1 Tablespoon”. Do NOT use non-standard measures such as “two bites”.
- For certain foods such as a banana or apple, you may write how much the child ate from the whole fruit, such as “1/2 apple” then fill in the blank next to the last check box by writing “whole” for the unit of measure. You can write the word “piece” or “whole” in the blank space.

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)		How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB))			If you used the Measurement Guide to estimate amount consumed, check box. Measurement Guide?
				Food	Drink/Beverage		
5	12:00pm	Banana, mashed <input type="checkbox"/> Mom nursed	<input checked="" type="checkbox"/> From home <input type="checkbox"/> From provider	1/4	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input checked="" type="checkbox"/> whole	<input type="checkbox"/> FL OZ	

- Write down the number or fraction of teaspoons, tablespoons, ounces or cups.
- Below is a list of conversions for your convenience.
 - o 8 fluid Oz = 1 cup
 - o 3 level teaspoons (tsp) = 1 level Tablespoon (TB)

If you do not use standard measuring tools:

- Use the images found on the following pages to estimate how much the infant ate or drank
- Indicate which serving dish was used (bowl, cup, spoon) by writing the code found beneath the image (B1, B2, B3, B4, C1, C2, S1, S2, S3, S4)
- Estimate how much was eaten (None, 1/4, 1/2, 3/4, All); for spoons, indicate whether the spoonful was mounded or not

Add a checkmark to the final column of the Infant Intake Module Form to indicate that you used the Measurement Guide to approximate the amount consumed.

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)		How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB))			If you used the Measurement Guide to estimate amount consumed, check box. Measurement Guide?
				Food	Drink/Beverage		
7	3:00pm	100% Juice: Apple <input type="checkbox"/> Mom nursed	<input type="checkbox"/> From home <input checked="" type="checkbox"/> From provider		<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB	1/4 C1 <input type="checkbox"/> FL OZ	<input checked="" type="checkbox"/>

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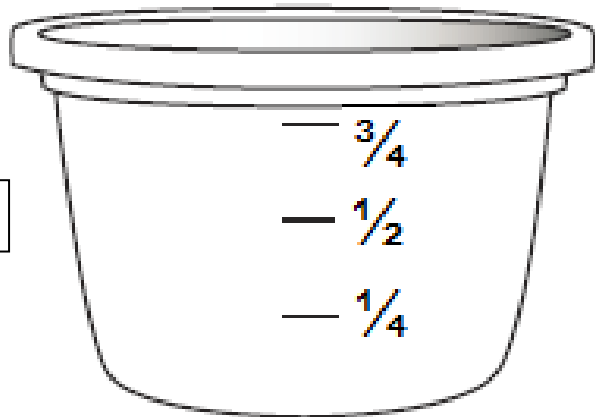
Tab 2

Measurement Guide

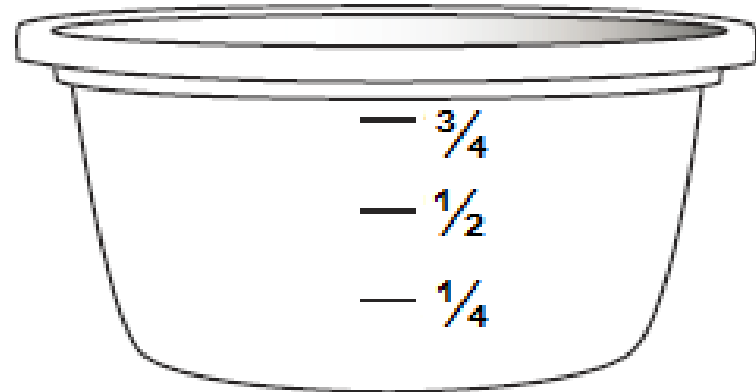
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Measurement Guide

Infant Bowls

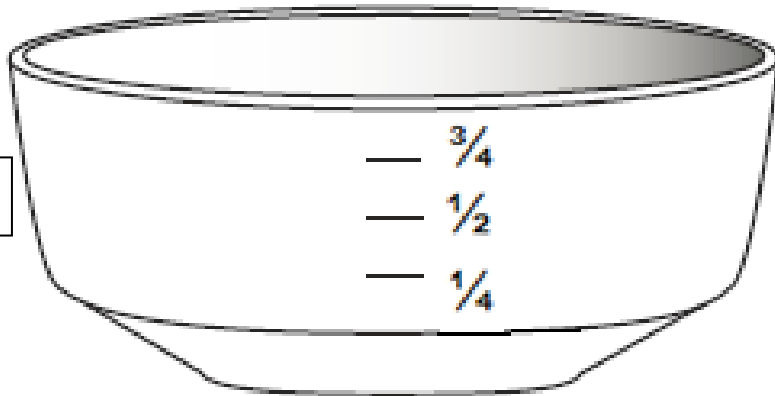


B 1

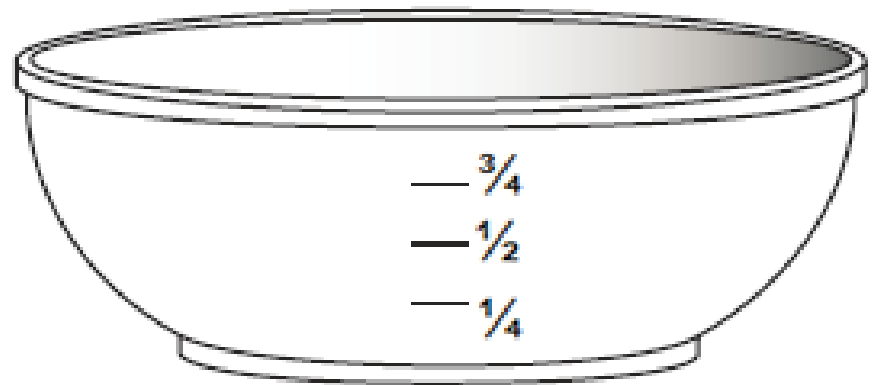


B 2

Child Bowls



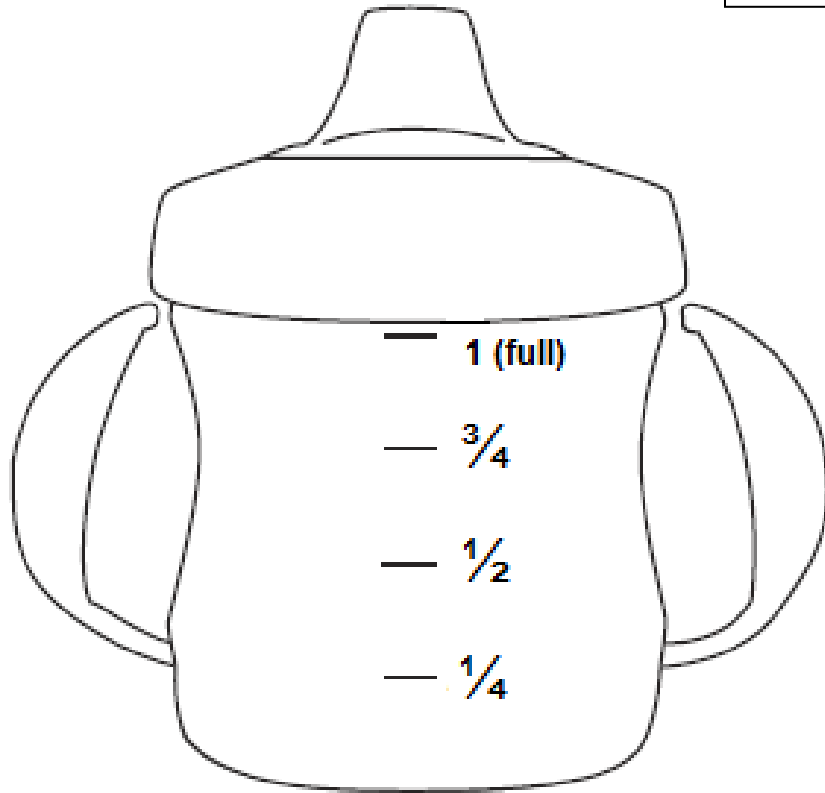
B 3



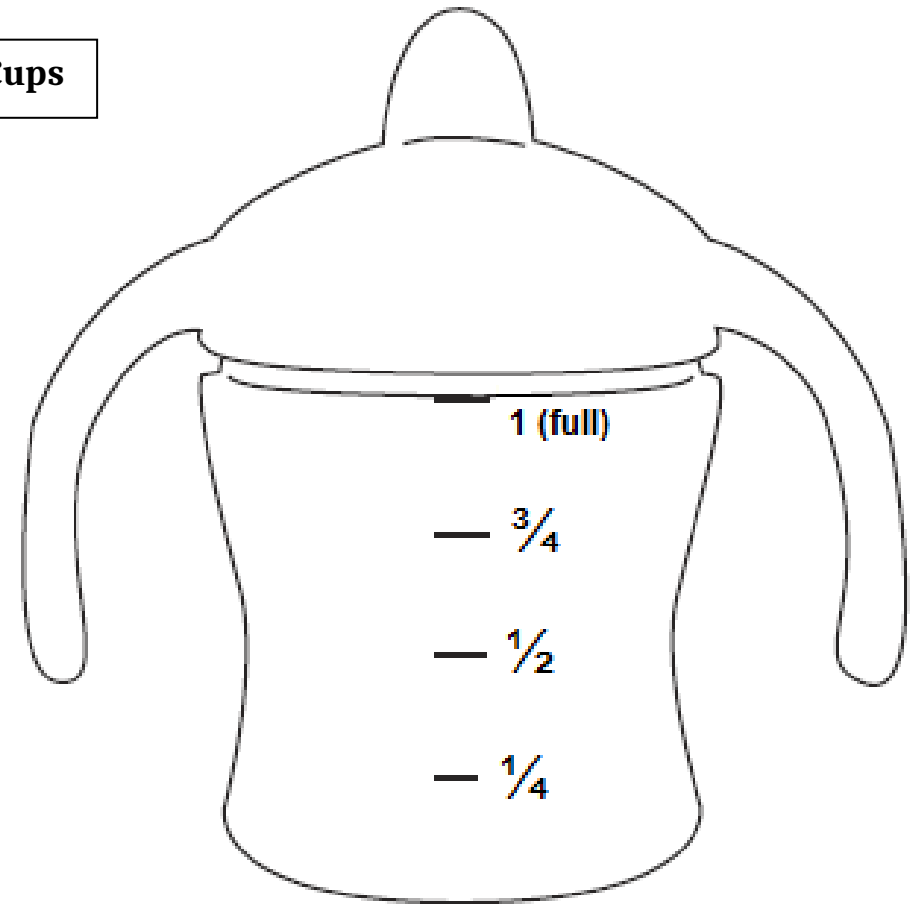
B 4

Measurement Guide, continued

Sippy Cups

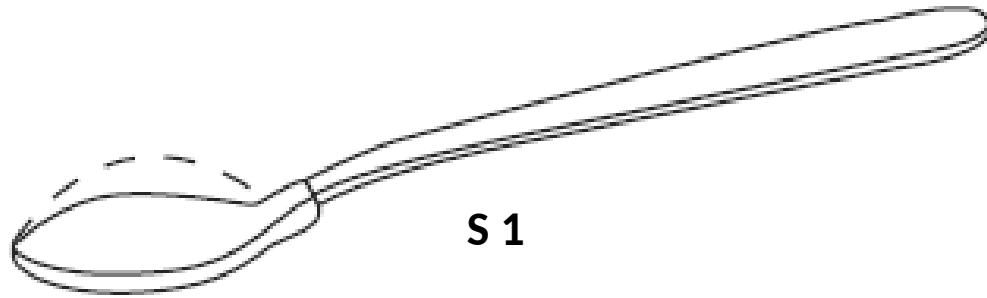


C 1



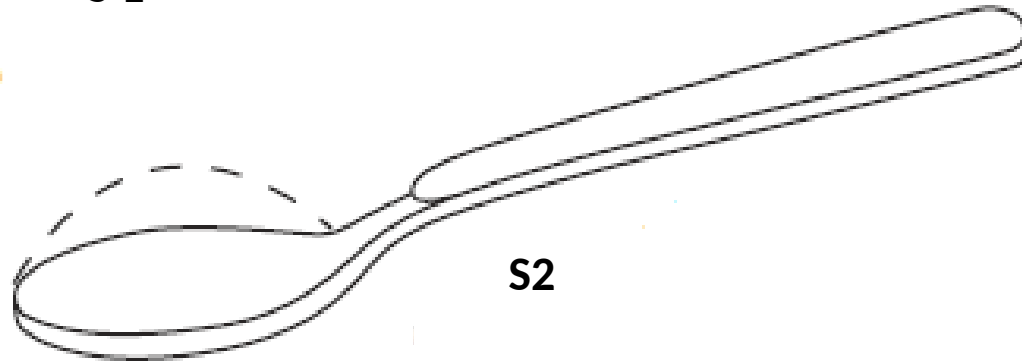
C 2

Measurement Guide, continued

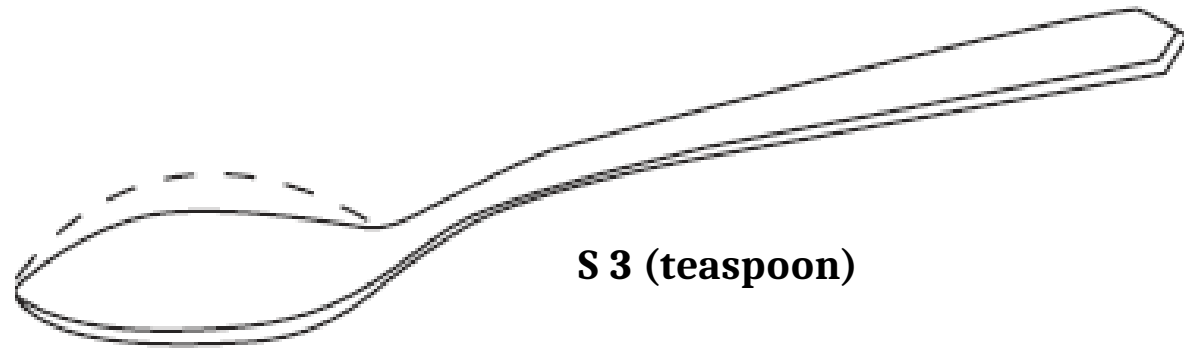


S 1

Infant Spoons

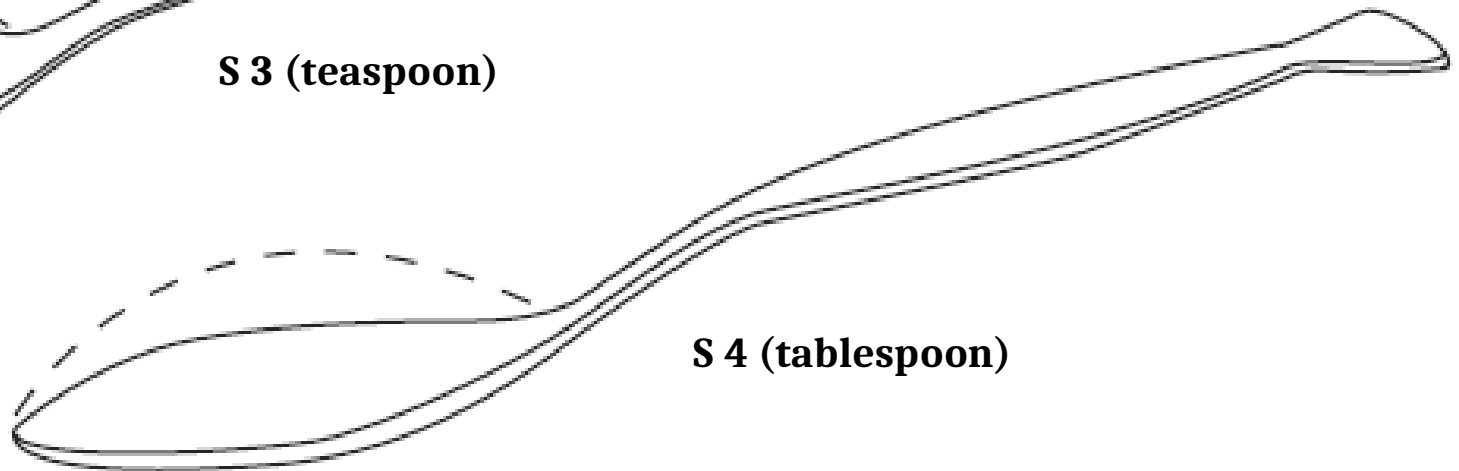


S 2



S 3 (teaspoon)

Standard Spoons



S 4 (tablespoon)

If you have any questions, please talk with the study team member that is at your program today. If you are unable to talk with the study team member while they are onsite, please call (toll-free) Abt Associates at 1- 844-808-4777 or email Abt Associates at SNACS@abtassoc.com.

Thank you very much for your help with this important study.

Tab 3

Example of a Completed Infant Intake Form

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Child ID #: _____

Today's Date: _____

Day of the Week (Please circle one): MON **TUES** WED THURS FRI
INFANT FOOD INTAKE FORM

Name of infant: Jackson Smith Birthdate of infant: 9/25/15 Gender (circle one): M **F**

Age of Infant (please circle one): 0 – 3 months 4 – 5 months **6 – 7 months** 8 months through 11 months

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)	How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB), or other		If you used the Measurement Guide to estimate amount consumed, check box.
			Food	Drink/Beverage	
1	8:00am	Breast milk <input type="checkbox"/> From home <input type="checkbox"/> From provider <input checked="" type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/>	N/A <input type="checkbox"/> FL OZ	
2	10:00am	Apple Sauce <input type="checkbox"/> From home <input checked="" type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	2 <input type="checkbox"/> Cups <input type="checkbox"/> tsp <input checked="" type="checkbox"/> TB <input type="checkbox"/>	<input type="checkbox"/> FL OZ	
3	12:00pm	Oatmeal <input type="checkbox"/> From home <input checked="" type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	1/4 <input checked="" type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/>	<input type="checkbox"/> FL OZ	
4	12:00pm	Breast milk <input checked="" type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/>	5 <input checked="" type="checkbox"/> FL OZ	
5	12:00pm	Banana, mashed <input checked="" type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	1/4 <input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input checked="" type="checkbox"/> whole	<input type="checkbox"/> FL OZ	
6	3:00pm	Breast milk <input checked="" type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/>	6 <input checked="" type="checkbox"/> FL OZ	
7	3:00pm	100% Juice : Apple <input type="checkbox"/> From home <input checked="" type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/>	1/4 C1 <input type="checkbox"/> FL OZ	<input checked="" type="checkbox"/>

The Infant Food Intake Form was adapted from the Infant Food Intake Record used in the Early Childhood and Childcare Study and the Childcare Food Information Form from the Feeding Infants in Childcare Study (FITS).

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Tab 4

Infant Intake Form—Infant 1

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OMB Control No: 0584-XXXX
OMB Approval Expiration Date: XX/XX/XXXX

INFANT FOOD INTAKE FORM

Infant 1

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Child ID #: |_|_|_|_|_|_|_|_|_|_|

Today's Date: _____

Day of the Week (Please circle one): **MON** **TUES** **WED** **THURS** **FRI**

INFANT FOOD INTAKE FORM

Name of infant: _____ Birthdate of infant: _____

Gender (circle one): **M** **F**

Age of Infant (please circle one): **0 – 3 months** **4 – 5 months** **6 – 7 months** **8 months through 11 months**

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)	How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB), or other		If you used the Measurement Guide to estimate amount consumed, check box.
			Food	Drink/Beverage	Measurement Guide?
1		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
2		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
3		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
4		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
5		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
6		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
7		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>

INFANT FOOD INTAKE FORM continued

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)	How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB), or other)		If you used the Measurement Guide to estimate amount consumed, check box.
			Food	Drink/Beverage	Measurement Guide?
8		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
9		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
10		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
11		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
12		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
13		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
14		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
15		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)	How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB), or other)		If you used the Measurement Guide to estimate amount consumed, check box.
			Food	Drink/Beverage	Measurement Guide?
16		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
17		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
18		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
19		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
20		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
21		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
22		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
23		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
24		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>

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Tab 5

Infant Intake Form—Infant 2

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INFANT FOOD INTAKE FORM

Infant 2

INFANT FOOD INTAKE FORM continued

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)	How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB), or other		If you used the Measurement Guide to estimate amount consumed, check box.
			Food	Drink/Beverage	Measurement Guide?
8		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
9		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
10		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
11		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
12		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
13		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
14		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
15		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)	How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB), or other)		If you used the Measurement Guide to estimate amount consumed, check box. Measurement Guide?
			Food	Drink/Beverage	
16		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
17		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
18		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
19		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
20		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
21		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
22		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
23		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
24		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>

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Tab 6

Infant Intake Form—Infant 3

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INFANT FOOD INTAKE FORM

Infant 3

Child ID #: |_|_|_|_|_|_|_|_|_|_|_|_|

Today's Date: _____

Day of the Week (Please circle one): **MON** **TUES** **WED** **THURS** **FRI**

INFANT FOOD INTAKE FORM

Name of infant: _____ Birthdate of infant: _____

Gender (circle one): **M** **F**

Age of Infant (please circle one): **0 – 3 months** **4 – 5 months** **6 – 7 months** **8 months through 11 months**

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)	How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB), or other		If you used the Measurement Guide to estimate amount consumed, check box.
			Food	Drink/Beverage	Measurement Guide?
1		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
2		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
3		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
4		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
5		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
6		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
7		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>

INFANT FOOD INTAKE FORM continued

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)	How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB), or other		If you used the Measurement Guide to estimate amount consumed, check box.
			Food	Drink/Beverage	Measurement Guide?
8		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
9		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
10		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
11		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
12		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
13		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
14		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
15		<input type="checkbox"/> Mom nursed <input type="checkbox"/> From home <input type="checkbox"/> From provider	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>

Office Use Only	Time of Feeding	What did you serve or feed? Use one line for each food or drink. (List all formula, breast milk, foods and drinks)	How much did the infant eat or drink? (Include units: Fluid ounces (FL OZ), cups, teaspoons (tsp), Tablespoons (TB), or other)		If you used the Measurement Guide to estimate amount consumed, check box.
			Food	Drink/Beverage	Measurement Guide?
16		<input type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
17		<input type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
18		<input type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
19		<input type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
20		<input type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
21		<input type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
22		<input type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
23		<input type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>
24		<input type="checkbox"/> From home <input type="checkbox"/> From provider <input type="checkbox"/> Mom nursed	<input type="checkbox"/> Cups <input type="checkbox"/> tsp <input type="checkbox"/> TB <input type="checkbox"/> _____	<input type="checkbox"/> FL OZ	<input type="checkbox"/>

The Infant Food Intake Form was adapted from the Infant Food Intake Record used in the Early Childhood and Childcare Study and the Childcare Food Information Form from the Feeding Infants in Childcare Study (FITS).