

INFANT MEAL PATTERN MENU

DELAWARE PARENTS ASSOCIATION INC.

418 South Governor's Ave Dover, De 19904

(302)678-9288*1-800-262-2080(DE Only)

Fax (302) 678-2730



Day Care Provider _____

Week of: _____ License Capacity _____ + _____

- ❖ Meals containing breast milk are reimbursable.
- ❖ Iron-fortified infant formula. Iron-fortified infant cereal
- ❖ Full-strength fruit juice, breads & crackers made from whole-grain or enriched meal or flour
- ❖ Infant dinners are not reimbursable

MEAL SERVED	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
(Circle One) BREAKFAST	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>
INFANT CEREAL										
FRUIT/VEG										
Child's Letter										
(Circle One) A.M./EVE SNACK	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>
100% JUICE										
BREAD										
Child's Letter										
(Circle One) LUNCH	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>
CEREAL/MEAT										
FRUIT/VEG										
Child's Letter										
(Circle One) P.M. SNACK	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>
100% JUICE										
BREAD										
Child's Letter										
(Circle One) SUPPER	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>	FORMULA OR BREAST MILK	<input type="checkbox"/>
CEREAL/MEAT										
FRUIT/VEG										
Child's Letter										

REQUIREMENTS FOR INFANT MEAL PATTERN

MEAL (Check box)	0-3 MONTHS <input type="checkbox"/>	4-7 MONTHS <input type="checkbox"/>	8-12 MONTHS <input type="checkbox"/>
BREAKFAST	4-6 fl. Oz. of FORMULA OR BREASTMILK	4-8 fl. Oz. of FORMULA OR BREASTMILK 0-3 tbsp. infant cereal	4-8 fl. Oz. of FORMULA OR BREASTMILK 2-4 tbsp. fruit/veg 2-4 tbsp. infant cereal
LUNCH OR SUPPER	4-6 fl. Oz. of FORMULA OR BREASTMILK	4-8 fl. Oz. of FORMULA OR BREASTMILK 0-3 tbsp. infant cereal 0-3 tbsp. fruit/veg	6-8 Oz. of FORMULA OR BREASTMILK 2-4 tbsp. infant cereal and/or meat, fish, egg yolk, cooked dry beans, peas, or cottage cheese. 1-4 tbsp. fruit/veg
SNACK	4-6 fl. Oz. of FORMULA OR BREASTMILK	4-6 fl. Oz. of FORMULA OR BREASTMILK	2-4 fl. Oz. of FORMULA/ BREASTMILK or fruit juice 0-1/2 slice bread or 0-2 crackers

Type of Formula _____

Child's Name _____

Child's Letter _____

Child's Name _____

Child's Letter _____