Daily Meal Production Record - Infants (1530-A)

CE Name: Coastal Child Nutrition Services

CE ID # (Five Digit): 02107

Date Meal was Served: / / 2019

Name of Site: ______

Site # (Four Digit): ______

Meal Service: ☐ B ☐ A ☐ L ☐ P ☐ S ☐ E

☐ Cycle Menu

Planned Participation	
Birth thru 5 months	
6 thru 11 months	

Age Group	Required Food Components	Infant Name	Age	Menu	Food Items Used (enter each food item used)	Iron Fortified	Quantity Prepared (measureable ammount)
Birth thru 5 months	**Breakfast, Lunch, Supper, Snack**		MOS.	☐ BM ☐ IF		☐	________ OZS
	4 - 6 fluid ounces breastmilk (BM) or infant formula (IF)		MOS.	☐ BM ☐ IF		☐	________ OZS
			MOS.	☐ BM ☐ IF		☐	________ OZS
			MOS.	☐ BM ☐ IF		☐	________ OZS
			MOS.	☐ BM ☐ IF		☐	________ OZS
			MOS.	☐ BM ☐ IF		☐	________ OZS
6 thru 11 months	**Breakfast, Lunch, Supper**		MOS.	☐ BM ☐ IF		☐	________ OZS
	6-8 fluid ounces breastmilk (BM) or infant formula (IF) **and,**			*		☐	
	0-4 tbsp infant cereal, **or**			*		☐	
	0-4 tbst meat, fish, poultry, whole egg,**or**		MOS.	☐ BM ☐ IF		☐	________ OZS
	0-4 tbsp cooked dry beans or dry peas, **or**			*		☐	
	0-2 oz cheese or 0-4 oz cottage cheese,**or**			*		☐	
	0-4 oz or 1/2 cup of yogurt, or a combination of the above* **and,**		MOS.	☐ BM ☐ IF		☐	________ OZS
	0-2 tbsp vegetable or fruit or a combination of both*			*		☐	
				*		☐	
	Snack		MOS.	☐ BM ☐ IF		☐	________ OZS
	2-4 fluid ounces breastmilk or infant formula **and**			*		☐	
	0-1/2 slice bread, or 0-2 crackers, or 0-4 tbsp infant cereal* **and**			*		☐	
	0-2 tbsp vegetable or fruit or a combination of both.*		MOS.	☐ BM ☐ IF		☐	________ OZS
				*		☐	
				*		☐	
**Required component when infant is developmentally ready*			MOS.	☐ BM ☐ IF		☐	________ OZS
				*		☐	
				*		☐	
			MOS.	☐ BM ☐ IF		☐	________ OZS
				*		☐	
				*		☐	
			MOS.	☐ BM ☐ IF		☐	________ OZS
				*		☐	
				*		☐	
			MOS.	☐ BM ☐ IF		☐	________ OZS
				*		☐	
				*		☐	

Daily Meal Production Record - Infants (1530-A)

Leftover/Recycled Food			
Date First Served	**Date Re-Served**	**Food Item**	**Quantity**

Substitutions due to Medical or Special dietary needs or disability			
Name of Infant	**Age**	**Substitution(s) Made**	**Item/Component Provided by Parent/Guardian-Y/N**
	mos.		☐ Yes ☐ No
	mos.		☐ Yes ☐ No
	mos.		☐ Yes ☐ No
	mos.		☐ Yes ☐ No
	mos.		☐ Yes ☐ No
	mos.		☐ Yes ☐ No
	mos.		☐ Yes ☐ No
	mos.		☐ Yes ☐ No

Comments (Record any other meal modifications or special instructions here) :
