

Promise Early Education Center Infant Menu

Provider Name: _____ Week Of: _____

Enrolled Infant Name : _____ Age: _____

Minimum amounts for 0-5 months, 6-11 months Indicated after food group.	Monday	Tuesday	Wednesday	Thursday	Friday
Breakfast					
Breast Milk or Formula 4-6 fl oz, 6-8 fl oz DO=doctor ordered substitute					
Vegetables, fruits, or combination (See infant meal pattern for amounts)					
Grains and/or meat/meat alternates (See infant meal pattern for amounts)					
Other Non-reimbursable extra food items					
A.M. Snack					
6-11 months 3 components					
Breast Milk or Formula 4-6 fl oz, 2-4 fl oz DO=doctor ordered substitute					
Vegetables, fruits, or combination (See infant meal pattern for amounts)					
Grain (See infant meal pattern for amounts)					
Other Non-reimbursable extra food items					
Lunch					
6-11 months 3 components					
Breast Milk or Formula 4-6 fl oz, 6-8 fl oz DO=doctor ordered substitute					
Vegetables, fruits, or combination (See infant meal pattern for amounts)					
Grains and/or meat/meat alternates (See infant meal pattern for amounts)					
Other Non-reimbursable extra food items					
P.M. Snack					
6-11 months 3 components					
Breast Milk or Formula 4-6 fl oz, 2-4 fl oz DO=doctor ordered substitute					
Vegetables, fruits, or combination (See infant meal pattern for amounts)					
Grain (See infant meal pattern for amounts)					
Other Non-reimbursable extra food items					

FOR OFFICE USE ONLY: Reviewed by: _____ Date: _____

This institution is an equal opportunity provider.