Consent to complement newborn infant feeds

I _____ wish/have been advised to give the following complementary feed to my baby. I have read and understood the information sheet, and understand that I can withdraw my consent at any time.

Name of complementary feed: _____ on: _____ at: _____
(Date) (Time)

Reason for complementary feed: _____

Formula requirement for baby (name): _____

Date of birth: _____ Time of birth: _____ Birth weight: _____

Formula brand: _____ 1 scoop to _____ mls of water

Signature of Mother: _____ Date: _____

The above consent applies only for complementary feeds necessary for the above stated reason. Each time the reason for the complement changes, a new consent form should be completed.

Office use (Health worker)
Please print, sign and file this form with the patients records.

Signature of Health Worker: _____ Date: _____

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