Weaning from supplements – weekly log

PERSONAL USE ONLY - DO NOT COPY

Last weight check (__________)__________ (DATE) (WEIGHT) **This weight check (__________)__________** (DATE) (WEIGHT) **Weight gain ________**

DAY # _____		Aim for 10 nursing/pumping sessions each day														TOTAL
Start Time																
How long did baby breastfeed?																
Supplement (ounces | mL)	Mom's Milk															
	Formula															
Pumping	How long? (min)															
	Amount (oz | mL)															

DIAPER COUNT

Wet	Soiled
W	S
W	S
W	S
W	
W	

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Wet	Soiled
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W	S
W	S
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