

Desiree Novak

Little People, BIG MINDS

Child's Name: _____

Date: _____

Time Arrived: _____

Time Departed: _____

Nap 1: Asleep: _____ am/ pm

Awake: _____ am/ pm

Nap 2: Asleep: _____ am/ pm

Awake: _____ am/ pm

Nap 3: Asleep: _____ am/ pm

Awake: _____ am/ pm

Time: Urine: _____ am/ pm

Urine: _____ am/ pm

Urine: _____ am/ pm

Urine: _____ am/ pm

Urine: _____ am/ pm

BM: _____ am/ pm

BM: _____ am/ pm

BM: _____ am/ pm

BM: _____ am/ pm

BM: _____ am/ pm

Disposition: AM: _____ Very Good

_____ Good

_____ OK

PM: _____ Very Good

_____ Good

_____ OK

MEALS	Time	Amount	What
B		<input type="checkbox"/> Didn't Eat <input type="checkbox"/> Ate OK <input type="checkbox"/> Ate Good <input type="checkbox"/> Had Seconds	
SN		<input type="checkbox"/> Didn't Eat <input type="checkbox"/> Ate OK <input type="checkbox"/> Ate Good <input type="checkbox"/> Had Seconds	
L		<input type="checkbox"/> Didn't Eat <input type="checkbox"/> Ate OK <input type="checkbox"/> Ate Good <input type="checkbox"/> Had Seconds	
SN		<input type="checkbox"/> Didn't Eat <input type="checkbox"/> Ate OK <input type="checkbox"/> Ate Good <input type="checkbox"/> Had Seconds	
DIN		<input type="checkbox"/> Didn't Eat <input type="checkbox"/> Ate OK <input type="checkbox"/> Ate Good <input type="checkbox"/> Had Seconds	
SN		<input type="checkbox"/> Didn't Eat <input type="checkbox"/> Ate OK <input type="checkbox"/> Ate Good <input type="checkbox"/> Had Seconds	

ACTIVITIES

Language & Auditory	<input type="checkbox"/> Talking <input type="checkbox"/> Stories <input type="checkbox"/> Music <input type="checkbox"/> Animal Sounds <input type="checkbox"/> See & Say <input type="checkbox"/> Instruments <input type="checkbox"/> Tapes <input type="checkbox"/> Sound Books <input type="checkbox"/> Fingerplays <input type="checkbox"/> Puppets <input type="checkbox"/> Other _____
Visual Skills	<input type="checkbox"/> Books <input type="checkbox"/> Mirror <input type="checkbox"/> Fish <input type="checkbox"/> Colors <input type="checkbox"/> Shapes <input type="checkbox"/> Mobiles <input type="checkbox"/> Peek A Boo <input type="checkbox"/> Video <input type="checkbox"/> Other _____
Manipulative	<input type="checkbox"/> Rattles <input type="checkbox"/> Blocks <input type="checkbox"/> Push N Pull Toys <input type="checkbox"/> Balls <input type="checkbox"/> Gym Toys <input type="checkbox"/> Busy Box <input type="checkbox"/> Rings <input type="checkbox"/> Painting <input type="checkbox"/> Clapping <input type="checkbox"/> Stacks <input type="checkbox"/> Dolls <input type="checkbox"/> Legos <input type="checkbox"/> Pegs <input type="checkbox"/> Roller <input type="checkbox"/> Crawling <input type="checkbox"/> Walking <input type="checkbox"/> Other _____
Equipment Used	<input type="checkbox"/> Walker <input type="checkbox"/> Swing <input type="checkbox"/> Rocking Horse <input type="checkbox"/> Slide <input type="checkbox"/> Other _____
Social	<input type="checkbox"/> Indoor Play <input type="checkbox"/> Outdoor Play <input type="checkbox"/> Party <input type="checkbox"/> Other _____
Child Needs	<input type="checkbox"/> Diapers <input type="checkbox"/> Wipes <input type="checkbox"/> Spare Clothes <input type="checkbox"/> Other _____

MEDICATION

Kind: _____ Beginning: _____ Until: _____
At: _____ / _____ / _____ / _____ Dosage: _____ Storage: _____
Parents Signature: _____ Date: _____

Additional Comments:

Parent's Special Instructions: