Infant Room – Your Child's Day

Name: _____ Date _____

How many hours did you child sleep last night? _____
Did you child eat breakfast? ☐ Yes ☐ No
Did you give your child any medication this morning? ☐ Yes ☐ No
Is there any other information you would like to share with us about your child since we saw him/her last? _____

Table Food:

Breakfast	Lunch	Snack
Wasn't hunger ☐	Wasn't hunger ☐	Wasn't hunger ☐
Ate Some ☐	Ate Some ☐	Ate Some ☐
Ate Everything ☐	Ate Everything ☐	Ate Everything ☐

Diaper Change
Wet ☐ Bowel Movement ☐ Diarrhea ☐ Constipated ☐

Today I enjoyed:

☐ Blocks	☐ Art	☐ Rocking Toys
☐ Cars & Trucks	☐ Dress Up/House play	☐ Outside play
☐ Dolls/Stuffed Animals/Puppets	☐ Going on a walk	☐ Running
☐ Animal Toys/Puzzles	☐ Water/Sensory table	☐ Sand play
☐ Beads maze	☐ Push & Pull Toys	☐ Climbing
☐ Looking at books	☐ Tent/playhouse	☐ Walking
☐ Listening to stories	☐ Musical toys	☐ Pulling self up
☐ Songs	☐ Tunnel	☐ Crawling
☐ Balls	☐ Rolling/turning over	☐ Sitting up
☐ Sensory/manipulative toys	☐ Activity Link Gym	☐ Bikes/scooter

Today I was:

☐ Happy	☐ Quieter than usual	☐ Energetic
☐ Busy exploring	☐ Cheerful	☐ Content
☐ Tired		

Today I napped:

Morning:	☐ Short	☐ Long
Afternoon	☐ Short	☐ Long

Things you should know about today

I have dirty clothes in my cubby ☐	I need extra clothes ☐
I need more diapers ☐	Check art folder ☐

Other information _____

_____