Children's House
Where Early Education Matters

INFANT DAILY ACTIVITY SHEET

Child's Name: _____ **Date:** _____

Who is picking up child today? _____ **Time:** _____

Food: What and when did your child eat/drink last:

What? _____ When? _____ a.m. / p.m.

Sleep: How many hours did your child sleep last night? From: _____ To: _____
From: _____ To: _____

Medication to be administered at center today? Yes _____ No _____
If yes, please include medication name and instructions for center: _____
_____

 # Bottles Brought In
_____

Special Instructions and/or Information: _____
_____

MEALS

	Time	Food / Bottle	Amt. Started	Amt. Taken	Initials
Bottles		*Bottle*			
		Bottle			
		Bottle			
		Bottle			
Breakfast					
Lunch					
Snack					

NAPS

	to	
	to	
	to	

MEDICATIONS

	at	
	at	

DIAPER CHECKS

Code: **D = Dry** **B = BM** **W = Wet** **S = Sleeping**

AM					PM					
7:__ _____	8:__ _____	9:__ _____	10:__ _____	11:__ _____	12:__ _____	1:__ _____	2:__ _____	3:__ _____	4:__ _____	5:__ _____

Your child needs: ☐ Diapers ☐ Food ☐ Other _____

Comments: