DAILY INFORMATION SHEET

Name of child Date

1. My child ate breakfast _____ _____
   Yes No
2. My child slept from _____to _____ last night.

   He/She slept well _____ _____
   Yes No
   If "NO," what seemed to be the problem?

3. My child is in a good mood. _____ _____
   Yes No
   If "NO," what seems to be the problem?

4. My child has had a bowel movement within the last 24 hours.
   _____ _____
   Yes No
5. Has your child been ill within the last week? (fever, diarrhea, cold symptoms, rash, etc.)

6. Are there changes in your child's routine (such as a new home, caregiver, potty training, etc.) or additional Information that will help us take better care of your child?

EMERGENCY CONTACT NAME AND NUMBER FOR TODAY

School for Little Children
Bellaire United Methodist Church
713.666.1111

_____
Name of child Date

1. Your child slept from _____to _____.

2. Bowel movement _____ _____
   Yes No

Your Child Played at the:

____ Book Corner ____ Sensory Table

____ Literacy Center ____ Manipulative Table

____ Home Living Center ____ Art

____ Rug Activities

We played: OUTSIDE IN THE GYM

Moment of the day: _____

_____

_____

_____

Next time please send:

Diapers Change of Clothes More Snack More Lunch