Christ Church Children's Center

HOME TO CHILD CARE TRANSITION

Date:_____

Child's Name:_____

Fell Asleep:_____ Woke Up:_____

Slept Okay: YES NO Notes:_____

_____

Time of Last Meal:_____

Last Meal Was: Bottle-_____oz

Food-_____

Last Diaper Change:_____

Child's General Mood This Morning:_____

_____

Special Notes to Caregivers:

YOUNGER INFANT DAILY CARE SHEET

Name:

BABY FOOD

Time	Type and Amount of Food
Special Notes:	

BOTTLES

Time	Amount	Time	Amount

DIAPERING

Time	Dry	Wet	BM	DC	Time	Dry	Wet	BM	DC
7:00					1:00				
9:00					3:00				
11:00					5:00				

NAPS

Fell Asleep	Woke-Up	Fell Asleep	Woke-Up

Please bring from home:

DIAPERS BABY FOOD CEREAL BIBS

CRIB SHEETS BLANKET BURP CLOTHES CLOTHING

Notes from Caregiver: