

CHILD'S NAME:

DATE:

HIGHLIGHTS - HEALTH AND WELLNESS

How did your child sleep last night? Woke up at:

Ate evening meal at:

Pick Up Information: Who: Time:

Phone number for today is:

Medications to be given at the Center: NO.....YES Type? When?

Medications given at home: Time: Type:

New illness symptoms, bumps, or bruises:

Was sunscreen applied today?YES.....NO

Parent's Notes:

.....

What I ate today:

Breakfast _____

Lunch _____

Snack _____

At Rest Time:


I slept / rested quietly:

From To


I brushed my teeth today:

.....YESNO


The World at Their Fingertips Curriculum - Ready for School




ART SMART




LANGUAGE WORKS/LITERACY




MATH COUNTS



UNDER CONSTRUCTION



SCIENCE ROCKS/SENSORY PLAY



Our World/Outdoor Play



Helping Children Succeed in School and Life



MOVEMENT MATTERS

