

CHILD'S NAME: Date:

HIGHLIGHTS - HEALTH AND WELLNESS

How did your child sleep last night? Woke up at:
 Last Diaper Change at (if applicable): Ate evening meal at:

Pick Up Information: Who: Time: Phone # 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 Notes:

Time	Initials	Diapering/Toileting	Sat on Toilet	Went on Toilet
.....	WET BM Dry
.....	WET BM Dry
.....	WET BM Dry
.....	WET BM Dry


At Rest Time:
 I slept / rested quietly:
 From To

I brushed my teeth today:
YESNO


Items I need at the Center: Diapers Wipes

Underwear Change of clothes Other


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

Highlight(s) and new discoveries of my day:



READY for SCHOOL
Helping Children Succeed in School and Life



MOVEMENT MATTERS
Movement Matters