



CHILD'S NAME: DATE:.....

HIGHLIGHTS - HEALTH AND WELLNESS

How did your child sleep last night? Woke up at:
 Last Diaper Change 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 Notes to Teachers:

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


 My teachers applied
 sunscreen atAM.....PM


Things I will need at the Center:
 Diapers
 Wipes
 Change of Clothes
 Other


The World at Their Fingertips Curriculum - Growing with Toddlers


 **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:

 **MOVEMENT MATTERS**