

# INFANT DAILY REPORT



**Infant Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

PARENT'S REPORT ABOUT INFANT	CHILD CARE PROVIDER REPORT ABOUT INFANT																																				
<p>Infant slept:   <input type="checkbox"/> Good   <input type="checkbox"/> OK   <input type="checkbox"/> Not well</p> <p>Infant seems:   <input type="checkbox"/> Happy   <input type="checkbox"/> Fussy   <input type="checkbox"/> Other</p> <p>Comments:</p> <p>Did the infant eat before coming to child care?   <input type="checkbox"/> No   <input type="checkbox"/> Yes</p> <p>Feeding Times</p> <p>Foods:</p> <p>Amount:</p>	<p style="text-align: center;"><b><u>Diapering/Toileting</u></b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Time</th> <th style="width: 10%;">Wet</th> <th style="width: 10%;">BM</th> <th style="width: 65%;">Description</th> </tr> </thead> <tbody> <tr><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>_____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> </tbody> </table>	Time	Wet	BM	Description	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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<p>Has infant had medication before coming?   <input type="checkbox"/> No   <input type="checkbox"/> Yes**</p> <p>** List the <b>names of medicine, amount given</b> and <b>time given</b></p>	<p style="text-align: center;"><b><u>Naptime/Sleeping<sup>1</sup></u></b></p> <p>Time to sleep: _____   Time awake: _____</p>																																				
<p>** Reasons for medicine:</p>	<p style="text-align: center;"><b><u>Today's Activities</u></b></p> <p><input type="checkbox"/> Music</p> <p><input type="checkbox"/> Reading / use of books</p> <p><input type="checkbox"/> Tummy time</p> <p><input type="checkbox"/> Physical activity</p> <p><input type="checkbox"/> Outdoors</p> <p><input type="checkbox"/> Other _____</p>																																				
<p>Special requests for infant today:</p>	<p style="text-align: center;"><b><u>Nutrition: Meals and Snacks</u></b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Feeding Time</th> <th style="width: 30%;">Foods</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Feeding Time	Foods	Amount																																	
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<p>What time will infant be picked up and by whom?</p>	<p style="text-align: center;"><b><u>Medication</u></b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name of Medicine</th> <th style="width: 20%;">Amount Given</th> <th style="width: 20%;">Time Given</th> <th style="width: 30%;">Staff initial</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name of Medicine	Amount Given	Time Given	Staff initial																																
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<p>Parent Signature: _____</p>	<p style="text-align: center;"><b><u>Infant's Mood and Disposition</u></b></p> <p>This morning the infant was:</p> <p style="text-align: center;"><input type="checkbox"/> Happy   <input type="checkbox"/> Fine   <input type="checkbox"/> A little fussy   <input type="checkbox"/> Very fussy   <input type="checkbox"/> Not well</p> <p>This afternoon/evening the infant was:</p> <p style="text-align: center;"><input type="checkbox"/> Happy   <input type="checkbox"/> Fine   <input type="checkbox"/> A little fussy   <input type="checkbox"/> Very fussy   <input type="checkbox"/> Not well</p> <p>During the night the infant was:</p> <p style="text-align: center;"><input type="checkbox"/> Happy   <input type="checkbox"/> Fine   <input type="checkbox"/> A little fussy   <input type="checkbox"/> Very fussy   <input type="checkbox"/> Not well</p> <p>Child Care Provider Signature: _____</p>																																				

<sup>1</sup> All infants are placed on their backs for nap/sleep. Infants who can freely turn from back - stomach – back on their own do not need to be repositioned onto their backs for nap/sleep.  
January 2010

# INFANT DAILY REPORT



**Infant Name:**

**Date:**

Additional instructions or comments may be written on the back of this form.

**Special Concerns or Instructions:** ( If the infant had an unusual day/night before coming to child care OR the infant became ill while attending child care, please list all symptoms and describe how the child progressed)

Parent Signature:

Child Care Provider Signature: