Your Infant’s Day

Child: ____________________________  Date: ____________________________

Last Ate: ____________

How I Slept:
- Soundly
- Did not sleep well
- To bed late
- Woke up early

Parent Comments:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Nap
- Slept ____________
  From ______ to ______
- Slept ____________
  From ______ to ______
- Slept ____________
  From ______ to ______

I Need:
- Diapers
- Wipes
- Extra clothes
- Diaper cream
- Sunscreen
- Other: ________

  I Have:
- Dirty clothes
- Mail
- Empty food containers
- Other: ________

Food

I drank:

___ oz of ____________ at ______
___ oz of ____________ at ______
___ oz of ____________ at ______
___ oz of ____________ at ______
___ oz of ____________ at ______
___ oz of ____________ at ______
___ oz of ____________ at ______

I ate:

___ of ____________ at ______
___ of ____________ at ______
___ of ____________ at ______
___ of ____________ at ______
___ of ____________ at ______
___ of ____________ at ______
___ of ____________ at ______

Diaper Changes

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- Don’t forget to check the whiteboard for our daily activities!