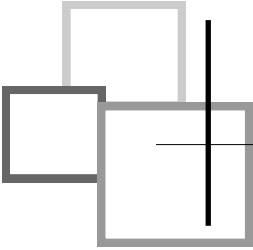


NURSERY CARE SHEET



Date _____

Circle Room

Infants to 25 months

2 to 3 years old

Child's Name (first/last) _____ Birth date _____

Person dropping off child _____ Relation to child _____

Location _____ Cell phone number _____

Snack ___ Goldfish ___ Cookies ___ Fruit snack ___ Crackers

Sleeps on ___ Stomach ___ Back ___ Side

Sleeps ___ Don't let fall asleep ___ Must be rocked ___ Falls asleep on own

Feeding ___ Milk Time _____ Warm/Cold (circle)

 ___ Water Time _____ Warm/Cold (circle)

 ___ Juice Time _____ Warm/Cold (circle)

 ___ Any of these are fine at anytime (toddler)

What can we do to comfort your child? None ___ Pacifier ___ Other _____

Allergies/Special instructions _____

Is your child potty training? (Yes / No) If yes, give instructions for toilet use _____

Extra Comments _____
