SUPPLEMENTAL HEALTH PROGRAM FOR CHILD CARE CENTERS PROVIDING INFANT-TODDLER CARE WEEKLY RECORD OF DAILY NEEDS

State Form 49960 (R3 / 2-15)

COPY TO PARENT or discuss on daily or weekly basis.

Name of child		
Special instructions for: (activity)		
(other)		

FSSA - MS02 402 WEST WASHINGTON STREET, RM W361 INDIANAPOLIS, IN 46204

A - ate well R - refused S - spit up V - vomited	Food and Fluids Time and Amount	Urine	B.M.	Awake Activities	Sleep # of Hours & Time	Mood: Happy, Crying, Quiet, Playful, etc.	Other: fever, skin rash, won't eat, still hungry, injury
Monday							
Staff Sig.							
Tuesday							
Staff Sig.							
Wednesday							
Staff Sig.							
Thursday							
Staff Sig.							
Friday							
Staff Sig.							