

Toddler Daily Record

Child's Name:	Date:				
	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time & Initials					
Departure Time & Initials					
Medicine: Check boxes	<input type="checkbox"/> form completed <input type="checkbox"/> fridge lock box <input type="checkbox"/> room lock box	<input type="checkbox"/> form completed <input type="checkbox"/> fridge lock box <input type="checkbox"/> room lock box	<input type="checkbox"/> form completed <input type="checkbox"/> fridge lock box <input type="checkbox"/> room lock box	<input type="checkbox"/> form completed <input type="checkbox"/> fridge lock box <input type="checkbox"/> room lock box	<input type="checkbox"/> form completed <input type="checkbox"/> fridge lock box <input type="checkbox"/> room lock box
Lunch: Meal: Milk or alternative:	____ serving(s) ____ cup(s)	____ serving(s) ____ cup(s)	____ serving(s) ____ cup(s)	____ serving(s) ____ cup(s)	____ serving(s) ____ cup(s)
Sleeptimes:					
Toileting:					
Parent's Messages & Concerns:					
Program Comments:					
Staff's Messages & Comments:					