

 Weekly Check in Form for the Week of : _____ Child name: _____					
Activities	Monday	Tuesday	Wednesday	Thursday	Friday
How did your child sleep last night?	<input type="checkbox"/> Fine <input type="checkbox"/> Other:	<input type="checkbox"/> Fine <input type="checkbox"/> Other:	<input type="checkbox"/> Fine <input type="checkbox"/> Other:	<input type="checkbox"/> Fine <input type="checkbox"/> Other:	<input type="checkbox"/> Fine <input type="checkbox"/> Other:
When did your child eat last?					
How is your child's mood today?	<input type="checkbox"/> Fine <input type="checkbox"/> Other:	<input type="checkbox"/> Fine <input type="checkbox"/> Other:	<input type="checkbox"/> Fine <input type="checkbox"/> Other:	<input type="checkbox"/> Fine <input type="checkbox"/> Other:	<input type="checkbox"/> Fine <input type="checkbox"/> Other:
Will you be picking up your child at the normal time today?	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____ When _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____ When _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____ When _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____ When _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____ When _____
Is there any medication that needs to be given to your child today?	<input type="checkbox"/> Yes <input type="checkbox"/> No (f there is, please complete a medical authorization form)	<input type="checkbox"/> Yes <input type="checkbox"/> No (f there is, please complete a medical authorization form)	<input type="checkbox"/> Yes <input type="checkbox"/> No (f there is, please complete a medical authorization form)	<input type="checkbox"/> Yes <input type="checkbox"/> No (f there is, please complete a medical authorization form)	<input type="checkbox"/> Yes <input type="checkbox"/> No (f there is, please complete a medical authorization form)
Were any medications given at home today?	<input type="checkbox"/> Yes <input type="checkbox"/> No What _____ And when was the last time you gave it to your child _____	<input type="checkbox"/> Yes <input type="checkbox"/> No What _____ And when was the last time you gave it to your child _____	<input type="checkbox"/> Yes <input type="checkbox"/> No What _____ And when was the last time you gave it to your child _____	<input type="checkbox"/> Yes <input type="checkbox"/> No What _____ And when was the last time you gave it to your child _____	<input type="checkbox"/> Yes <input type="checkbox"/> No What _____ And when was the last time you gave it to your child _____
Any cold or illness symptoms?					
Any new bumps or bruises?					
Additional Comments					