

# Daily Activity Log



# DAILY CHILD INSTRUCTIONS AND ACTIVITY LOG

The Daily Child Instructions and Activity Log is a form provided by Bright Horizons to provide clear communication between the parent or guardian and the in-home caregiver. Parents/Guardians: Please complete the appropriate sections of the form with information about all children receiving care. Review it with the caregiver prior to your leaving and remind them to fill out the last sheet to share with you when you return.

### Employee Details:

Employees Name:	
Phone number:	
Best number to reach me on today:	
What time will the caregiver be relieved?	
By Whom?	
Are there any custody issues?	
If yes, please describe:	
Is there anyone who is not allowed in the home?	
If yes, please list their names:	

### Alternative Contact Details:

<b>Contact #1</b>	
Name	
Relationship to the person(s) being cared for	
Address	
Telephone number:	Mobile number:
<b>Contact #2</b>	
Name	
Relationship to the person(s) being cared for	
Address	
Telephone number:	Mobile number:



### Emergency Contact Information

GP Name	
Address	
Phone number:	
Preferred Hospital:	
Other Emergency Numbers:	

**Child(ren)'s Information:** - Please include details and instructions for all children receiving care

Child's Name	Child's Date of Birth	Child's Age

### Child Health Information:

	Child 1 -	Child 2 -	Child 3 -
Has your child received medication today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please provide name of medication, time of dose and reason			
Has your child had this medication before without any side effect?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have any injuries or symptoms of illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list any allergies your child may have:			
Please describe any symptoms/treatments of known allergic reactions:			

### Toileting:

	Child 1 -	Child 2 -	Child 3 -
Potty trained?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nappy Routine			
Time of most recent nappy change			
Nappy routine – ointment /powder?			
Special instructions			

### Feeding Details:

	Child 1 -	Child 2 -	Child 3 -
What does your child drink from- Bottle/trainer cup/cup?			
How does your child take their bottle – warm/room temperature/cold			
Will your child feed him/herself?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child use a dummy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Special instructions?			

### Likes and Dislikes:

	Child 1 -	Child 2 -	Child 3 -
Food Likes			
Food Dislikes			

## Feeding Routine

Please provide usual times for bottles/meals	Child 1 -	Child 2 -	Child 3 -
Breakfast			
Snack			
Lunch			
Snack			
Tea			
Dinner			

## Sleeping Schedule:

It is the policy of Bright Horizons and the Back-Up Care Programme that all infants be put to sleep on their backs on a firm infant cot mattress in a cot. When infants can easily turn over from the back to the stomach position, they will continue to be put down to sleep on their back, but allowed to adopt whatever position they prefer to sleep.

Providers in the Back-Up Care Programme are required to comply with these protocols, and may not place an infant in our care on his/her stomach for sleep. Any requests by parents to do so cannot be honoured. If the parents insist that their child must be put to sleep on his/her stomach, care will be denied.

	Child 1 -	Child 2 -	Child 3 -
Nap schedule for the day			
Does your child put him/herself to sleep?			
Does he/she need assistance? Provide detail			

**Daily Routine:**

	Child 1 -	Child 2 -	Child 3 -
Morning			
Afternoon			
Evening			
Late Night			

**Activities and Hobbies:**

	Child 1 -	Child 2 -	Child 3 -
Preferred activities?			
Computer/games console/ TV rules and restrictions?			
Special instructions or information carer should know?			



# Bright Horizons Back-Up Care Programme

## In-Home Child Care Information Sheet

### Daily Experience Sheet Caregiver Information

\*Please leave this form for the caregiver to fill out regarding your child's day\*:

Caregiver's Name:

\_\_\_\_\_

Date:

\_\_\_\_\_

<b>Child 1 (name)</b>			
<b>Feeding</b>			
Time	Amount	Type	
<b>Nappy Changes</b>			
Time	Wet	Dry	BM
<b>Naps</b>			
Morning			How long
Afternoon			How long

<b>Child 2 (name)</b>			
<b>Feeding</b>			
Time	Amount	Type	
<b>Nappy Changes</b>			
Time	Wet	Dry	BM
<b>Naps</b>			
Morning		How long	
Afternoon		How long	

<b>Child 3(name)</b>			
<b>Feeding</b>			
Time	Amount	Type	
<b>Nappy Changes</b>			
Time	Wet	Dry	BM
<b>Naps</b>			
Morning		How long	
Afternoon		How long	



What activities did the child(ren) participate in today?

Notes about the day: *(use reverse side if needed)*