Early Head Start Infant/Toddler

Daily Information Exchange

Date: ____________ Child's Name: ______________________________

Did your child sleep well last night? ☐ Yes ☐ No

What time did your child wake up this morning? ___________________________

At what time did your child last eat? ___________________________________

What new foods are you introducing to your child? _________________________

Is your child on any medication? ☐ Yes ☐ No If yes, what? _____________

Who is picking up child? ________________ At what time? _______________

Special Instructions/Comments: ____

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Breakfast/A.M. Snack:

Lunch/P.M. Snack:

Naptime:

Diapers/Toileting:

Individualized Schedule: ____

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Songs: ♬

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Books:

Primary Caregiver's Signature: ____