CHILDCARE DROP OFF INFORMATION SHEET

Child's Name:	Date:
Previous Nights Sleep: ( ) Well - Hours ( ) Unsettled ( ) Other Information - ______________________________ ______________________________ ______________________________	Medication given at home: ( ) Yes - ______________________ Reason: ______________________ ( ) Other Health Information - ______________________________ ______________________________ ______________________________
Breakfast: ( ) Yes at _____ a.m. ( ) Food: ______________________ ( ) No	Pickup Details: ( ) Person ______________________ ( ) Approx Time __________________ ( ) Other ______________________
Contact Details for the day: Name 1:______________________ Numbers: ______________________ Name 2:______________________ Numbers:______________________	Other News/Updates/Requests: