

Nursery Childcare Information

Parent, please complete this section:

Child's name: _____ Age: _____

Mother's Name: _____

Cell phone #: _____

Pager #: _____ Sleep in car seat? YES NO

My child will need a BOTTLE at: _____

(bottle DOES DOES NOT need to be warmed)

Please check if your child is BREASTFED only: _____

Approximate time for snack: _____

Approximate time for nap: _____

(sleeps on BACK STOMACH)

Comfort item: _____

Cry time: _____

----- TO BE FILLED IN BY NURSERY STAFF -----

Bottle - Time: _____ Type: _____

NAP-Time: _____

Diaper change - Time: _____ Wet BM

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