Daily Care Plan

Child's Name: _____ Nickname: _____ Day/Date: _____
Diagnosis: _____
Allergies (include food allergies): _____
_____
_____
Medications: (See Daily Medication Chart)
_____

Meal Times
Breakfast _____ Lunch _____Dinner_____
General Diet: _____ Special Diet: _____
Favorite Foods: _____
Special Utensils? _____ Special Dishes? _____
Snacks ~ What? _____ When? _____
Feeding tube: Y ___ N ___ Feeding Tube Care: _____
Oral Care: _____

Equipment (Wheelchair, walker, standing frame, high chair, braces, crutches, etc.)
_____
_____
_____
_____
_____

Daily Activities
Crawls: _____ Stands Alone: _____ Walks Alone:_____
Stands With Assistance: _____ Walks With Assistance:_____
Favorites Activties:_____
Favorite Toy: _____
Activities to Avoid: _____
Plays Outside:_____
Plays Inside: _____ Where? _____
Range Of Motion/Exercises: _____
_____
_____
_____
_____

Calming/Comfort Techniques (Rocking, singing, quiet, favorite song, pacifier, etc. etc.)
_____
_____
_____
_____
_____
_____
_____
_____

Daily Care Plan

Nap Time

Time: _____ Place: _____
Favorite Blanket? _____
Favorite Stuffed Toy: _____
Special Pillow? _____Music? _____

Diapering/Toileting

Location of supplies: _____Diaper Rash Crème: _____
Frequency of changes/toileting: _____
Skin Changes? (Rashes, redness, open sores, etc. etc.) _____
Toilets Independently? Y_____ N_____ Needs assist with transfer: _____
Special Equipment: _____
Extra Safety Measures: _____
Personal Care Equipment (Catheter, ostomy bags, stoma care, etc. etc.) _____
_____
_____
Skin Care: _____

Bedtime Routine

Time: _____ Place: _____
Bath: _____
Skin Care: _____
Pajamas are kept _____
Nightlight? _____ Favorite Blanket? _____
Favorite Comfort Item/Stuffy? _____
Special Pillow: _____
Bedtime Story: _____
Music? _____
Medicines (see medication chart) _____

Comments:

_____
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