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| --- | --- | --- | --- |
| Name: | [Name] | | |
| Day of the Week | [Day] | Date: | [Date] |

|  |  |  |  |
| --- | --- | --- | --- |
| Evaluate / Assets With | |  | Notes |
| Nutrition | Breakfast |  |  |
| A.M Snacks |  |  |
| Lunch |  |  |
| P.M Snacks |  |  |
| Dinner |  |  |
| Liquid |  |  |
|  | | | |
| Hygiene | Shower/Bath |  |  |
| Brushed Teeth |  |  |
| Combed Hair |  |  |
| Clothes Changed |  |  |
| Other: [Other] |  |  |
|  | | | |
| Health | Sleep |  |  |
| Exercise/Activity |  |  |
| AM Medications |  |  |
| PM Medications |  |  |
| Urine/Bowel Movement |  |  |
|  |  |  |  |
| Other / Additional Notes |  |  |  |
|  |  |  |
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