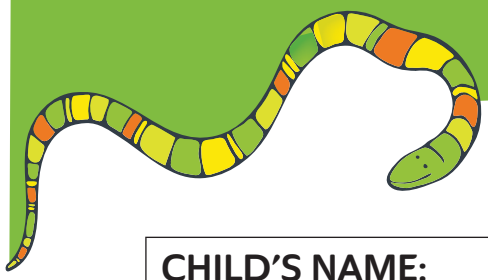


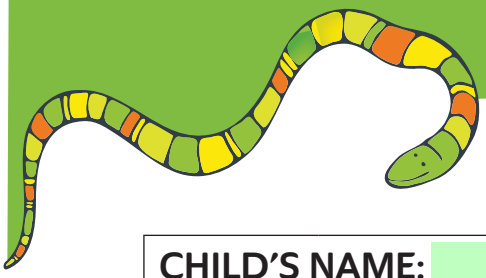
NURSERY ROUTINE FORM

YOUR CHILD'S DAY

CHILD'S NAME:		
FEEDING		
Your child is currently feeding on:	FORMULA ☐ MILK ☐ BREAST MILK ☐	
Bottle Times:		
Does your child like to be nursed when having a bottle:	YES ☐ NO ☐	
Does your child usually drink the whole bottle:	YES ☐ NO ☐	
Does your child need to be burped during a bottle:	YES ☐ NO ☐	If **YES**, how many times?
Does your child have reflux or any other feeding concerns:	YES ☐ NO ☐	If **YES**, please provide details:

EATING		
Does your child have any dietary restrictions /allergies?	YES ☐ NO ☐	If **YES**, please provide details:
Does your child like to feed themselves?	YES ☐ NO ☐	
What kind of appetite does your child have?	SMALL ☐ MEDIUM ☐ LARGE ☐	

FEEDING		
How does your child go to sleep?		
Does your child like to be patted?	YES ☐ NO ☐	
Does your child have a comforter to go to sleep?	YES ☐ NO ☐	If **YES**, how many times?
Day Sleep:	FROM:	TO:
	FROM:	TO:
	FROM:	TO:



NURSERY ROUTINE FORM

WHAT YOUR CHILD DOES & WHEN

CHILD'S NAME:	
TIME	**ROUTINE**
6 – 7am	
7 – 8am	
8 – 9am	
9 – 10am	
10 – 11am	
11am – 12pm	
12 – 1pm	
1 – 2pm	
2 – 3pm	
3 – 4pm	
4 – 5pm	
5 – 6pm	