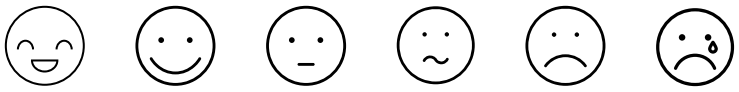
DAILY CARE SHEET

DATE:

M	T	W	T	F	S	S

MEDICATION	
Morning	
Afternoon	
Evening	
Night	

OVERALL MOOD / PAIN NO.		
M		
A		
E		
N		



0 2 4 6 8 10

H - Happy I - Irritated A - Anxious
V - Vibrant S - Sad F - Fearful N - Neutral
M - Angry D - Depressed B - Bored

DRINKS

H2O							
Shake							
Other							

VITALS			
Time		Blood Pressure	
Weight		Body Temp	
SpO2		Pulse	

MEALS / SNACKS

FOOD	TIME	AMOUNT
		G F P
		G F P
		G F P
		G F P
		G F P

ACTIVITIES	TIME	PLACE

HYGIENE	
Teeth	
Bathing	
Hair/Face	

NAP TIME	LENGTH

OUTPUT

TIME	AMOUNT S / M / L / oz	COLOR	PAIN 0-10	URGENCY YES / NO	ACCIDENT YES / NO

C - Clear **D** - Dark Yellow **K** - Pink **T** - Red + Clots **L** -Cloudy
P - Pale Yellow **Y** - Yellow **R** - Bright Red **B** - Brown **O** - Orange

NOTES: