

Parent's TIME-OUT, Inc.

Family Name: _____ Date: _____

We will be at: _____ Until: _____ Phone No. There: _____

Alternate Contact (Neighbor, Friend, Relative): _____

Please contact us if the following occurs: Fever over _____ Crying for longer than _____ Vomiting Injury

HOUSEHOLD INFORMATION:

Safety

Alarm Location/Instructions: _____

Location of: House Key, Fire Extinguisher, First Aid Kit, Flash light and Fuse Box: _____

Information about locking doors and/or windows: _____

Pets

Pets in Household: _____

Instructions for Pets (i.e. feeding, areas they are allowed, etc.): _____

_____ Friendly? _____

Household Rules

Meal Instructions: _____

Toileting Instructions: _____

Sleep/Nap Instructions: _____

Discipline/Behavior Instructions: _____

Activities Allowed/Encouraged: _____

Are there any visitors expected (housekeepers, grandparents, neighbor children, etc): _____

RULES:

TV/Computer/Video Games:	
Food:	
Phone/Friends:	
Homework/Chores:	

MEDICATIONS TO BE GIVEN

Child's Name	Name of Medication	Amount	Method (i.e. by mouth, topical, etc.)	Any Known Reactions	Time to be Given	Actual Time Given

I authorize the Nanny to dispense the above listed medications: _____

PTO015

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While I Visited With Your Child(ren)

Child's Name:			
What & When he/she ate:			
Our activities were:			
Disposition was: (i.e. happy, energetic, talkative, quiet, friendly, pleasant, or sleepy)			
Toileting occurred at: (also designate B/M or Wet)			
He/she slept from & to: and again from & to:			
Other:			
I noticed that you are out of (or running low on) the following items:			

I noticed the following (re: sleeping, behavior, toileting, eating, etc.): _____

Nanny's Name: _____

Phone Numbers: _____