Center:_____

DAILY SENSORY HEALTH CHECK

Date:_____

KEY

1=Temperament/Mood (Listen) *mood, sickness, behavior
2=Physical Appearance (Look) *skin, breathing, behavior.
3=Temperature (Feel) *warm, cold, clammy
4=Odor (Smell) * foul, fruity, other

Reviewed By/Date_____
Action Needed ☐ Not Needed ☐
Follow Up Date_____

If there is a concern regarding one of these areas, please write the number you think it pertains to and the observation you made. If everything is okay with the child for that day, please write "OK".

NAME OF CHILD	Monday	Tuesday	Wednesday	Thursday