Sleep Chart

Month: _____

Year: _____

_____
(name of childcare facility)

N.C. licensing rules require that babies 12 months of age or younger be placed on their back to sleep, unless a signed waiver states otherwise. Providers must keep a daily record of how they visually check sleeping babies. Keep this record for at least one month after the reporting month. Providers must decide how often their facility will check sleeping babies. *Note*: Checking every 15 minutes is reasonable.

Instructions: Complete this form each time staff visually checks sleeping infants. Use the chart for an individual baby or list several babies – if you check them all together. Write the name of each baby checked in the *Name* column. Staff doing the checking must note the times and put their initial.

Check the **Sleep Position** and **Code Letter:** *B*=Back; *Si*=Side; *T*=Tummy (Stomach) to indicate the baby's sleep position when FIRST placed to sleep and when checked. Write additional comments describing the infant's sleep such as "rolled over for the first time, " in the comment space provided.

Baby's Name:	Date: Sleep Time: Initial:	Position when FIRST placed to sleep:	1 Time Checked & Initial: *Baby's Position:*	2 Time Checked & Initial: *Baby's Position:*	3 Time Checked & Initial: *Baby's Position:*	4 Time Checked & Initial: *Baby's Position:*	5 Time Checked & Initial: *Baby's Position:*
Name: _____ Comments:	Date: _____ Time: _____ Initial: _____	□ **Back** □ **Side** □ **Tummy**	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*
Name: _____ Comments:	Date: _____ Time: _____ Initial: _____	□ **Back** □ **Side** □ **Tummy**	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*
Name: _____ Comments:	Date: _____ Time: _____ Initial: _____	□ **Back** □ **Side** □ **Tummy**	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*
Name: _____ Comments:	Date: _____ Time: _____ Initial: _____	□ **Back** □ **Side** □ **Tummy**	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*

Sleep Chart

Month: _____

Year: _____

Baby's Name:	Date: Sleep Time: Initial:	Position when FIRST placed to sleep:	**1** Time Checked & Initial: *Baby's Position:*	**2** Time Checked & Initial: *Baby's Position:*	**3** Time Checked & Initial: *Baby's Position:*	**4** Time Checked & Initial: *Baby's Position:*	**5** Time Checked & Initial: *Baby's Position:*
Name: _____ *Comments:*	Date: _____ Time: _____ Initial: _____	□ *Back* □ *Side* □ *Tummy*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial:_____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*
Name: _____ *Comments:*	Date: _____ Time: _____ Initial: _____	□ *Back* □ *Side* □ *Tummy*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial:_____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*
Name: _____ *Comments:*	Date: _____ Time: _____ Initial: _____	□ *Back* □ *Side* □ *Tummy*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial:_____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*
Name: _____ *Comments:*	Date: _____ Time: _____ Initial: _____	□ *Back* □ *Side* □ *Tummy*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial:_____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*
Name: _____ *Comments:*	Date: _____ Time: _____ Initial: _____	□ *Back* □ *Side* □ *Tummy*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*	Time:_____ Initial:_____ □ *B* □ *Si* □ *T*	Time:_____ Initial: _____ □ *B* □ *Si* □ *T*
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Instructions: Check the **Sleep Position** and **Code Letter:** *B*=Back; *Si*=Side; *T*=Tummy (Stomach) to indicate the baby's sleep position when FIRST placed to sleep and when checked. Write additional comments in the comment space provided.

Sample by: North Carolina Healthy Start Foundation 6/04

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