15 MINUTE NAP CHECK LOG

(Must be kept on file for 3 years)

Name of Infant: _____ Room: _____

Name of Staff _____ Initials _____
Name of Staff _____ Initials _____
Name of Staff _____ Initials _____
Name of Staff _____ Initials _____

Date	Time	Position (Circle one)	Signs of Distress? (Circle one)	Staff Initials
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	
	AM PM	Back Stomach Side	NO YES	