



PLEASE PRINT AND WRITE LEGIBLY!
NIGHT SHIFT DAILY PROGRESS NOTE

Client Name: [REDACTED]
Target Behavior: [REDACTED]

Level of Supervision: CO

Date: 1-19-2020

SLEEPING PATTERNS <input type="checkbox"/> Encopresis <input type="checkbox"/> Enuresis <input type="checkbox"/> Did Not Sleep at All <input type="checkbox"/> All Night <input checked="" type="checkbox"/> Most of the Night <input type="checkbox"/> Often Awake	RESTRAINTS <input type="checkbox"/> Children's Control Position <input type="checkbox"/> Team Control Position <input type="checkbox"/> Transport <input type="checkbox"/> Short Personal Restraint <input checked="" type="checkbox"/> None	SERIOUS INCIDENTS (Fill in the type of incident.) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> None
LEVEL OF SUPERVISION <input checked="" type="checkbox"/> CO=Close Observations/Normal Supervision <input type="checkbox"/> ES= Eyesight <input type="checkbox"/> 1:1= One to One	BEHAVIOR CONSEQUENCES Any Behavior Consequence forms completed for this child? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	FYI's Any FYI Forms completed for this child? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

GENERAL NOTATION CATEGORIES

AFFECT:

<input type="checkbox"/> Sad/ Depressed	<input type="checkbox"/> Angry/ Irritable	<input type="checkbox"/> Disappointed	<input type="checkbox"/> Inclusive/ Impulsive
<input type="checkbox"/> Anxious/ Worried	<input type="checkbox"/> Scared	<input type="checkbox"/> Silly/ Childish	<input checked="" type="checkbox"/> Compliant
<input type="checkbox"/> Restless	<input type="checkbox"/> Happy	<input type="checkbox"/> Frustrated	<input type="checkbox"/> (Other)

Program Restrictions and/or Precautions: Close observation

DAILY NARRATIVE (Attach an addendum for additional information)

Client was asleep in room upon arrival. client awoke at 9:15pm and said her leg was hurting, gave her water and she went back to bed. woke up again at 1:40am complaining of pain in her Right leg (calf area) and was limping when she walked. Tossed and turned most of the night until 2:45am. was give some ~~tylenol~~ ^{ibuprofen} ~~Ibuprofen~~. Client slept the rest of the night.

Staff Reporting: [REDACTED]

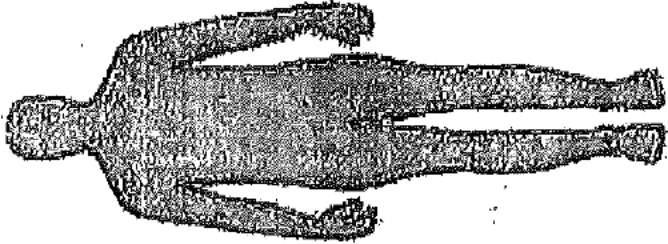
Time of Entry: 6:00 am

Signature of Facility Administrator or Designee:

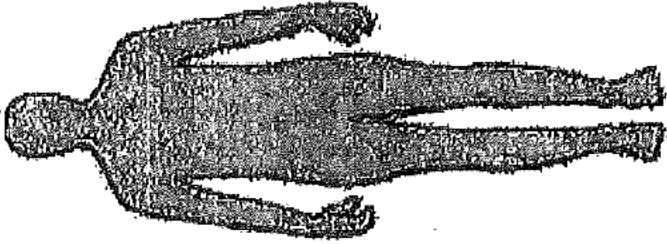
HEALTH CHECK-Only if needed
CIRCLE YES OR NO ON THE CHART LISTED BELOW

1. Scrapes/ Abrasions: Yes or No 2. Birthmark: Yes or No 3. Bruises: Yes or No 4. Scratches/ Lacerations: Yes or No 5. Deformities: Yes or No 6. Pierced Ears, Nose, Body Parts: Yes or No 7. Lice: Yes or No	8. Lesions: Yes or No 9. Rashes: Yes or No 10. Scars: Yes or No 11. Tattoos: Yes or No 12. Prosthesis: Yes or No Other: <u>N/A</u>
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if a "YES" response is indicated, mark the body figures with the appropriate number in the area the abnormality is located. Add a description of these in the "Comments Section." Describe the color of all bruises and the color, length, and width of all scars.



FRONT



BACK

Comments:

N/A

Form Completed by:

[Redacted]
Staff Print Name

[Redacted]
Staff Signature

1-19-20
Date