

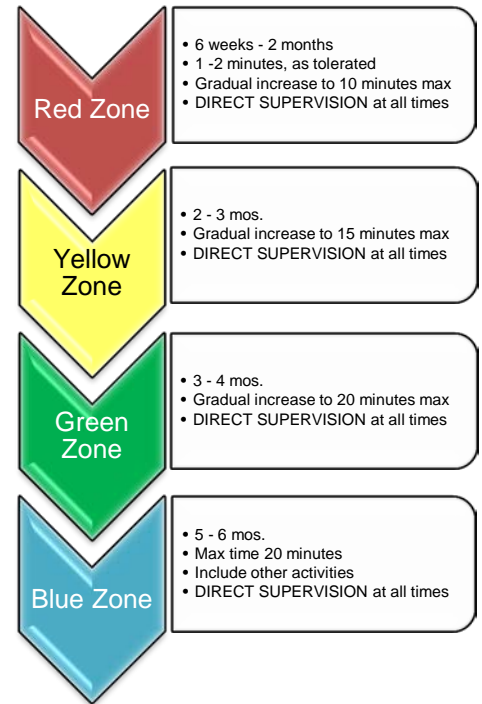
## TUMMY TIME QUICK LIST



NAME: \_\_\_\_\_

LEVEL of CARE: Red Yellow Green Blue

Section A – ASSESS		If NO, reschedule		YES	NO
Is the infant's behavior:	Normal	<input type="checkbox"/>	<input type="checkbox"/>		
Is the infant awake:	Alert	<input type="checkbox"/>	<input type="checkbox"/>		
	Ready to play	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Section B – If YES to any of these questions, no Tummy Time</b>					
Is the infant's skin:	Flushed?	<input type="checkbox"/>	<input type="checkbox"/>		
	Pale?	<input type="checkbox"/>	<input type="checkbox"/>		
	Splotchy?	<input type="checkbox"/>	<input type="checkbox"/>		
Does the infant have nasal congestion or a cough?		<input type="checkbox"/>	<input type="checkbox"/>		
Is the infant on medication(s)?		<input type="checkbox"/>	<input type="checkbox"/>		
If the infant had a bottle recently, has the infant experienced:	Reflux?	<input type="checkbox"/>	<input type="checkbox"/>		
	Projectile?	<input type="checkbox"/>	<input type="checkbox"/>		
Is the infant's behavior:	Different?	<input type="checkbox"/>	<input type="checkbox"/>		



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<b>Section B – if YES to any of these questions, no Tummy Time</b>					
Is the infant's skin:	Flushed?	<input type="checkbox"/>	<input type="checkbox"/>		
	Pale?	<input type="checkbox"/>	<input type="checkbox"/>		
	Splotchy?	<input type="checkbox"/>	<input type="checkbox"/>		
Does the infant have nasal congestion or a cough?		<input type="checkbox"/>	<input type="checkbox"/>		
Is the infant on medication(s)?		<input type="checkbox"/>	<input type="checkbox"/>		
If the infant had a bottle recently, has the infant experienced:	Reflux?	<input type="checkbox"/>	<input type="checkbox"/>		
	Projectile?	<input type="checkbox"/>	<input type="checkbox"/>		
Is the infant's behavior:	Different?	<input type="checkbox"/>	<input type="checkbox"/>		

