Date: _____

Personal Hygiene Checklist

Skill	Observed			Notes
Child's Name:	Yes	No	N/A	If no or N/A, please explain:
1. Does the child wash their hands regularly and when necessary?				
2. Does the child shower regularly and when necessary?				
3. Does the child use necessary hygiene products (deodorant, lotions, feminine products, etc.)?				
4. Does the child use appropriate bathroom habits (wipe correctly, proper disposal, etc.)?				
5. Does the child brush their teeth at least twice a day?				
6. Does the child practice other healthy dental habits (floss, mouthwash, etc.)?				
7. Does the child have a regular sleeping pattern (sleep through the night, night terrors, bed wetting, etc.)?				
8. Does the child practice a healthy lifestyle (nutrition, physical activity, etc.)?				
9. Is the child aware of their medical and mental health needs (Know what medications they are on)?				
10. Does the child understand their medical and mental health needs ? Can they be self-sufficient in addressing their own medical and mental health needs?				
11. Does the child exhibit any concerning behaviors that can be linked to disabilities or mental health issues?				

Please return to: _____

or 5403 Avenue N Rosenberg, TX 77477 P: 281-344-5130/5146 F: 281-341-0798