SLEEP DIARY

Please answer the questions on the following pages as accurately as you can, including your child's input as much as possible. Please answer separately for each of the 5 days. There are no right or wrong answers.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
What time did your child attempt to fall asleep last night?					
What time did your child wake up today?					
After your child went to sleep last night, how many times did he/she wake up during the night?					
How well did your child sleep? (Rate from 1 to 10)					
Did your child take any medication to help them fall asleep last night? If yes, what medication did your child take?					
Did your child have any pain the night before?					
Was there any noise or disruptive light in the room while your child was sleeping at night?					
Was blood drawn while your child was sleeping at night?					
Have your child's vital signs (blood pressure, temperature, etc.) been measured while he or she was sleeping at night? How many times was ıt measured?					
Did your child nap today?					
Did your child receive chemotherapy today?					
Did your child receive radiotherapy today?					