FORM C: DAILY KMC COMPLIANCE FORM

Objective: *To record the number of hour of KMC given to the baby admitted in the KMC unit in 24 hours (8AM - 8AM), the duration of each session and the reason for not giving continuous KMC. To be collected by nurse on duty in KMC room via direct observation or from mother/caregiver*

Day: Tuesday **Hospital Reg. No.:** 6

Date of Birth(dd/mm/yy) : 20/12/2019 **Mothers Name:**

S.No	Starting time of KMC	Stopping time of KMC	Duration of KMC per episode (if KMC duration>=1hour then record in hours if <1 hour please record in minutes)	Reason for pausing KMC (Breast feeding,doctorcheckup,mothers mealtime,mothers personal care,family visit,discomfort,complications,etc.)	KMC Provider	Nurse Name	Nurse Signature
1	6:00 AM	1:00 PM	07:00		Grand Mother	Seema	
2							
3							
4							
5							
6							
7							
8							
	Total KMC duration in 24 hours (8 am to 8 am): 07:00						