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: Thursday Hospital Reg. No.:

Date of Birth(dd/mm/yy): 27/03/2020 Mothers Name: And Then

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	1:00 AM	11:59 PM	22:59		Mother	jekson		
2								
3								
4								
5								
6								
7								
8								
	Total KMC duration in 24 hours (8 am to 8 am):							
	22:59							