

# Weekly Exercise, Nutrition and Hydration Tracking

**Special Olympics**  
New Mexico



**ATHLETE NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**MOVEMENT**

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	WEEK TOTALS	GOAL TOTALS	GOAL REACHED?
<b>Did I Do an Activity That Made Me Sweat Today?</b>  Fill in Yes or No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Sweaty Days  _____/7	<b>Sweaty Days</b> <b>GOAL</b> <b>5 of 7</b>	Fill in Star if you got sweaty 5 out of the 7 days.  
	If Yes - What did I do? _____ _____	If Yes - What did I do? _____ _____	If Yes - What did I do? _____ _____	If Yes - What did I do? _____ _____	If Yes - What did I do? _____ _____	If Yes - What did I do? _____ _____	If Yes - What did I do? _____ _____			
	_____	_____	_____	_____	_____	_____	_____			

**NUTRITION**

<b>Did I Eat Fruit Today?</b>  Yes or No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Fruit or Vegetables I ate this week  _____/35	<b>Number of Fruit or Vegetables Eaten</b> <b>GOAL</b> <b>Total of 21/35</b>  (Doesn't matter combination)	Fill in Star if your total is 21 or more, regardless of combination.  
	<b>Did I Eat Vegetable Today?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

**WATER**

<b>Did I Drink 5 Cups of Water today?</b>  Fill in Yes or No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	 <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Days I Drank 5 Cups of Water  _____/7	<b>Days with Water</b> <b>GOAL</b> <b>7 of 7</b>	Fill in star if you drank water everyday.  
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