CHILD SYMPTOM RECORD

Child's Name: _____ Date: _____ Time: _____

MAIN SYMPTOM: _____

When it began: _____ How long lasted:_____

Other symptoms: _____

Temperature: _____ Time taken: _____

CIRCLE THE SYMPTOMS

BREATHING	cough	wheezing	fast breathing	difficulty breathing	other:			
SKIN	pale	flushed	rash	sores	swelling	bruises	itchiness	Other
VOMITING # of times: _____ Time began:_____ Time stopped: _____				**Diarrhea: # of times: _____ Time began: _____ Time stopped: _____**				
EYES	pink/red	Watery	discharge (yellow/green)	crusty	swollen	other:		
MOUTH	sores	drooling	difficulty swallowing	other :				
PAIN	throat	stomach (abdomen)	head	ears	mouth/teeth	other:		

Liquids (name, amount, time): _____ Food: (type, amount, when) _____

Sleep: _____ Medications (name, amount, time): _____

Measures Taken: _____

Comments: _____

Staff Signature: _____ Parent/Guardian: _____

***original to parent/guardian *copy made for center files * fax to health services (276-679-7869)**

☐ **Please follow – up with your child's health care provider regarding the symptoms listed above. A written note, along with specific instructions, from the health care provider is necessary before your child may return to head start.** ***(visit to health care provider is only required by head start if the box is checked)***

To The Health Care Provider: Please complete the following information

Name of HCP: _____ Phone # : _____

Please indicate when child may return to Head Start: _____

Information/Special Care Instructions: _____

HCP signature: _____ Date: _____