Illness Report

Child's name____D.O.B_____________
Center____Teacher______________________
Parent(s)______________________________________Number______________________

MAIN SYMPTOM____
When it began_________________________? How long has I lasted? _________________
Complaints from thechild:____

CIRCLE THE SYMPTOMS:
Breathing: *coughing* *wheezing* *fast* *difficult*
other_____________________________
Skin: *pale* *flushed* *rash* *sores* *swelling* *bruises* *itchiness*
other_________________
Vomiting: (# of times)________________________Diarrhea (# of times)___________________
Eyes: *pink/red* *watery* *discharge* *crusty* *swollen* other________________________
Nose: *congested* *runny* *excessive bleeding* other_____________________
Mouth: *sores* *drooling* *difficulty swallowing*
other______________________________

TEMPERATURE - 99.1 degrees or higher (auxiliary).99.5 degrees higher(oral). 100.4 degrees higher(rectal)
Temperature_______________times taken Temperature___________________times taken
Hair and Scalp: *head lice nits(eggs) dry& itchy* *oozing sores* *hair loss*

WHAT HAS BEEN DONE TO COMFORT THE CHILD? ______________________________
Liquids (name, amount, time) _______________________Food(name, amount, time)__________
Emergency Measures____
Who was Called and what time____
Symptom status at time of pick up____

Your child may return to the center under the following conditions:
____After exclusion from the center for 24 hours
____With a doctor's note stating that the symptoms exhibited by your child are not contagious to the other children in our care.

Teacher Signature___________________________________Date_____________________

Parent/Guardian Signature_____________________________Date_____________________

DirectorSignature_____________________________________Date________________