

## Report of Symptoms to Parents

Child's Name:	Age:	Birth date:	Today's Date:
Temperature is: <span style="float: right;">°F</span>	Time taken:	Temperature was taken by:	
		<input type="checkbox"/> Under arm <input type="checkbox"/> Ear canal <input type="checkbox"/> Mouth	

**If temperature is above 104° under the arm of any child or above 100° for baby under the age of four months old call 911.**

**Please check all that apply.**

<p style="text-align: center;"><b>Skin</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Flushed <input type="checkbox"/> Hot <input type="checkbox"/> Dry <input type="checkbox"/> Pale <input type="checkbox"/> Perspiring <input type="checkbox"/> Bruise     Blue around mouth or fingertips  Color: Location: Other:	<p style="text-align: center;"><b>Nose</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Bloody <input type="checkbox"/> Mucous  Color: Other:	<p style="text-align: center;"><b>Bowel Movements</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Hard <input type="checkbox"/> Number <input type="checkbox"/> Abnormal <input type="checkbox"/> Loose, watery color <input type="checkbox"/> Bloody <input type="checkbox"/> Black <input type="checkbox"/> Other:
<p style="text-align: center;"><b>Rash</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Itchy <input type="checkbox"/> Raised <input type="checkbox"/> Hives <input type="checkbox"/> Blisters  Color: Location: Other:	<p style="text-align: center;"><b>Breathing</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Noisy <input type="checkbox"/> Difficulty <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing <input type="checkbox"/> Fast <input type="checkbox"/> Other:	<p style="text-align: center;"><b>Urination</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Very dark <input type="checkbox"/> Every _____ minutes <input type="checkbox"/> None in ≥ 8 hours <input type="checkbox"/> Bloody <input type="checkbox"/> Other:
<p style="text-align: center;"><b>Ears</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Pain <input type="checkbox"/> Other: <input type="checkbox"/> Drainage	<p style="text-align: center;"><b>Appetite</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Not eating <input type="checkbox"/> Excessive eating <input type="checkbox"/> Other:	<p style="text-align: center;"><b>Body Motion</b></p> <input type="checkbox"/> Unusual restlessness <input type="checkbox"/> First seizure/convulsion <input type="checkbox"/> Neck stiffness and pain <input type="checkbox"/> Other:
<p style="text-align: center;"><b>Eyes</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Watery <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Yellow drainage <input type="checkbox"/> Uneven pupils <input type="checkbox"/> Other:	<p style="text-align: center;"><b>Vomiting</b></p> <input type="checkbox"/> A large part of feeding <input type="checkbox"/> With unusual force <input type="checkbox"/> Mucous <input type="checkbox"/> Clear <input type="checkbox"/> Between feedings <input type="checkbox"/> Bloody <input type="checkbox"/> After head injury <input type="checkbox"/> Other:	<p style="text-align: center;"><b>Sleep</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Unusually drowsy <input type="checkbox"/> Cannot get to sleep <input type="checkbox"/> Difficult to awaken <input type="checkbox"/> Other:
<p style="text-align: center;"><b>Behavior</b></p> <input type="checkbox"/> Normal <input type="checkbox"/> Irritable <input type="checkbox"/> Persistent crying <input type="checkbox"/> Unusually confused <input type="checkbox"/> Other:		

Action taken: <i>(List medications and treatment given)</i>	
Child care staff signature:	Date:

**Please see flyer, "Keep me home if..." for a list of symptoms which require you to find other arrangements for sick child care. For more information, call the Communicable Disease Outreach Program at 425.339.5278.**