Symptom Record

Child's Name _____Date:_____

Symptoms:
Circle or write in other symptoms:

runny nose sore throat cough vomiting diarrhea wheezing

trouble breathing stiff neck rash trouble urinating pain

itching trouble sleeping earache headache stomachache

Other symptoms:
_____
_____

When symptoms began, how long they lasted, how severe, how often?
_____
_____

Changes in the child's behavior
_____
_____

Child's temperature: _____ Time taken: _____ (Circle: armpit, oral, or ear canal)

Type and quantity of food and fluid the child ingested in the past 12 hours?
_____
_____

Frequency of urine and bowel movement, in the past 12 hours? Any abnormalities?
_____

Exposure to medications, animals, insects, soaps, new foods:
_____
_____
_____

Exposure to other people ill with similar symptoms? Yes No Unsure
If yes, type of illness or symptoms
_____
_____

Child's other medical conditions that might affect this illness (for example: asthma, anemia, diabetes, allergies, and emotional trauma)

_____

Treatment for given to date and person providing treatment.

_____

_____

Child should be excluded from child care: YES NO
If yes, when can child return to care:

_____?

Advice from the child's clinician: _____

_____

Name and title of person completing this form:

_____

Phone number of person completing this form: _____

*Adapted from Model Child Care Health Policies, PA Chapter-American Academy of Pediatrics. (2002) 4thj Ed.