Hoosier Uplands Children's Services Illness Report

Child/Pregnant Parent Name_____ DOB_____

Teacher/HV _____ Center/County _____

About the Illness Date of Illness_____ Time of Illness_____

☐Viewed by staff ☐ Reported by parent Main Illness Symptom_____

Additional Symptoms Temperature_____ ☐ear ☐underarm ☐ mouth

1.) Skin: ☐pale ☐red cheeks ☐rash ☐sores ☐itchiness ☐swelling ☐bruises

2.) Eyes: ☐pink/red ☐watery ☐drainage ☐crusty ☐swollen ☐ other _____

3.) Ears: ☐tugging at ears ☐drainage ☐complaining of ache ☐other _____

4.) Nose: ☐congested/stuffy ☐ runny drainage ☐other _____

5.) Mouth: ☐sores ☐drooling ☐difficulty swallowing ☐other _____

6.) Breathing:☐coughing ☐wheezing ☐breathing fast ☐difficulty breathing ☐other

Care Given

Comfort Measures/Medications Given_____

Time & Type of Last Liquid Intake_____

Time & Type of Last Food Intake _____

Parent / Guardian Notification Notified By: ☐note ☐phone ☐in person

☐Staff informed parent of need for child to go to the doctor for check up & diagnosis.

☐Child Taken Home ☐Child Remained in Center ☐Child Taken to Doctor

Name of Doctor _____ Doctor Appointment Date _____

Additional Comments **(regarding diagnosis, temporary exclusion period, treatments, etc.)**

Staff Signature_____ (R 071510 mkm Word;R 11/99)

Optional Education

☐ Education Provided to Parent/Guardian by _____

Type of Education _____ Date Given _____

CC: Parent, Child File, Head Start Health Specialist/EHS Nurse