Symptom Record Form

Instructions: This form may be used by families or teachers/caregivers to document symptoms at home or while the child is in the program. Use the back of the form if more space is needed.

Name of facility/school: _____

Child's first and last name: _____

Date: _____ Symptom(s): _____

When symptom began, how long it lasted, how severe, how often? _____

Any change in child's behavior? _____

Child's temperature if taken: _____ Time taken: _____ (Circle: axillary [armpit], oral, rectal, ear canal, other [specify]) _____

How much and what type of food and fluid did the child take in the past 12 hours? _____

_____

Number of times of urination: _____ and bowel movements: _____

How typical/normal for this child were urine and bowel movements in the past _____ hours? _____

_____

Circle or write in other symptoms:

Cough	Headache	Runny nose	Stomachache	Trouble urinating	Other pain (specify) _____
Diarrhea	Itching	Sore throat	Trouble breathing	Vomiting	_____
Earache	Rash	Stiff neck	Trouble sleeping	Wheezing	_____

Other symptoms: _____

Any medications in the past 12 hours (name, time, dose)? _____

Any exposure to animals, insects, soaps, new foods, or new environments? _____

Exposure to other people who were sick; who and what sickness? _____

Child's other problems that might affect this illness (eg, asthma, allergy, anemia, diabetes, emotional trauma, seizures): _____

_____

What has been done so far? _____

Advice from the child's health professional: _____

First and last name of person completing this form: _____

Relationship of person completing this form to the child: _____