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:		Sym	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 pasthours?					
Circle or write in other symptoms:					
Cough	Headache	Runny nose	Stomachache	Trouble urinating	Other pain (specify)
Diarrhea	ltching	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:					

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