# Symptoms or Suspected Illness—Sample A

(See alternate type of form on page 178.)

Name of Child ____________________________________________________________  
Facility/School _____________________________  Date __________________________

Dear Parent/Guardian:

Today at our facility/school, your child was observed to have one or more of the following signs or symptoms:

<table>
<thead>
<tr>
<th>General</th>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Fever (101°F [38.3°C] or above orally or axillary)</td>
<td>□ Infected skin patches</td>
</tr>
<tr>
<td>□ Complained of headache</td>
<td>□ Crusty, bright yellow, dry, or gummy areas of skin</td>
</tr>
<tr>
<td>□ Swelling of or pus from __________________________</td>
<td>□ Severe itching of body/scalp</td>
</tr>
<tr>
<td>Eye</td>
<td>□ Unusual spots or rashes</td>
</tr>
<tr>
<td>□ Pinkeye</td>
<td>□ Head lice or nits</td>
</tr>
<tr>
<td>□ Tears, redness of eyelid lining</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Unusual behavior</td>
</tr>
<tr>
<td>□ Diarrhea ______ times in the last 24 hours (had an abnormally loose stool)</td>
<td>□ Loss of appetite</td>
</tr>
<tr>
<td>□ Vomiting ______ times in the last 24 hours</td>
<td>□ Child cries more than usual</td>
</tr>
<tr>
<td>Respiratory</td>
<td>□ Child feels general discomfort</td>
</tr>
<tr>
<td>□ Difficult or rapid breathing</td>
<td>□ Cranky or less active</td>
</tr>
<tr>
<td>□ Severe coughing</td>
<td>□ Just seems unwell</td>
</tr>
<tr>
<td>□ Child gets red or blue in the face</td>
<td></td>
</tr>
<tr>
<td>□ Trouble swallowing or complained of sore throat</td>
<td></td>
</tr>
<tr>
<td>□ Earache or signs that suggested earache (specify)</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>Urine problem</td>
</tr>
<tr>
<td>□ Infected skin patches</td>
<td>□ Specify</td>
</tr>
<tr>
<td>□ Crusty, bright yellow, dry, or gummy areas of skin</td>
<td></td>
</tr>
<tr>
<td>□ Severe itching of body/scalp</td>
<td>Other</td>
</tr>
<tr>
<td>□ Unusual spots or rashes</td>
<td>□ Specify</td>
</tr>
<tr>
<td>□ Head lice or nits</td>
<td></td>
</tr>
</tbody>
</table>

Contact your health professional if there is

□ Persistent fever (above 101°F [38.3°C]) and child seems very sick

□ Breathing so hard child cannot play, talk, cry, or drink

□ Severe coughing

□ Earache

□ Sore throat with fever

□ Thick nasal drainage that lasts more than 10 days

□ Rash accompanied by fever

□ Persistent diarrhea (more than 1–2 days)

□ Severe headache and stiff neck with fever

□ Yellow skin and/or eyes

□ Considerable confusion or difficult to aroused

□ Rash, hives, or welts that appear quickly

□ Severe stomachache that causes child to double over and scream

□ No urination over 8-hour period; mouth and tongue look dry

□ Black stool or blood mixed with stool

□ Any child who looks or acts very ill or seems to be getting worse quickly

We are excluding your child from attendance at our facility/school until

□ The signs or symptoms that required exclusion have resolved.

□ The child can comfortably participate in normal activities.

□ We can provide the level of care your child needs.

□ Other

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Symptoms or Suspected Illness—Sample B
(See alternate type of form on page 177.)

Name of facility/school
________________________________________________________________________________________

Child’s name
_____________________________________________________________________________________

Date ___________________________________________ Symptom(s) ___________________________

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

_______________________________________________________________________________________________________

Any change in child’s behavior? ____________________________________________________________________________

_______________________________________________________________________________________________________

Child’s temperature _____________ Time taken _____________ (Circle one: Armpit Oral Rectal Ear canal)

How much and what type of food and fluid did the child take today? _______________________________________________

_______________________________________________________________________________________________________

How many urine and bowel movements today and how typical/normal were they? _____________________________

_______________________________________________________________________________________________________

Check the appropriate box(es) or write in other symptoms.

☐ Runny nose ☐ Sore throat ☐ Cough ☐ Diarrhea
☐ Wheezing ☐ Trouble breathing ☐ Stiff neck ☐ Trouble urinating
☐ Pain ☐ Itching ☐ Trouble sleeping ☐ Earache
☐ Headache ☐ Stomachache ☐ Rash ☐ Vomiting

Other symptoms _________________________________________________________________________________________

_______________________________________________________________________________________________________

Any medications today? (name, time, dose) _________________________________________________________________

_______________________________________________________________________________________________________

Exposure to chemicals, animals, insects, soaps, or new foods ________________________________________________

_______________________________________________________________________________________________________

Exposure to other people who were sick (what sickness?—for confidentiality reasons, please do not identify individuals) _____

_______________________________________________________________________________________________________

Child’s other problems that might affect this illness (eg, asthma, anemia, diabetes, allergy, emotional trauma) ______

_______________________________________________________________________________________________________

What has been done so far? _____________________________________________________________________________

_______________________________________________________________________________________________________

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