

Module 3: Recognizing & Managing Communicable Diseases

Handout I: Symptom Record

Child's name: _____ Date: _____

MAIN SYMPTOM

When it began _____ How long it has lasted _____

How much _____ How often _____

Staying constant, getting better or worse? _____

OTHER SYMPTOMS: Complaints _____

General appearance (e.g., comfort, mood, behavior, activity level, appetite) _____

CIRCLE THE SYMPTOMS:

Breathing: coughing wheezing breathing fast difficulty breathing other _____

Skin: pale flushed rash sores swelling bruises itchiness other _____

Vomiting: (# times) _____ Diarrhea (# times) _____ Urine _____

Eyes: pink/red watery discharge crusty swollen other _____

Nose: congested runny other _____

Ears: pulling at ears discharge other _____

Mouth: sores drooling difficulty swallowing other _____

Odors: (e.g., breath, stool) _____

Temperature: _____ (axillary, oral, rectal, other _____)

WHAT HAS BEEN DONE: Comfort _____ Rest _____

Liquids (name, amount, time) _____ Food (name, amount, time) _____

Medications (name, amount, time) _____

Emergency measures _____

Who was called and when (e.g., parent/guardian, emergency contact person, health consultant, child's health provider, emergency medical services) _____

Signature _____

Adapted from: *Model Child Care Health Policies*, American Academy of Pediatrics, Pennsylvania Chapter, 1993, and *Healthy Young Children: A Manual for Programs*, National Association for the Education of Young Children, 1995.