East Missouri Action Agency, Inc.
HEAD START
"An Equal Opportunity/Affirmative Action Employer"

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: General appearance or problems with comfort, mood, behavior, activity level, appetite, etc.) Description or observation: ________________________________

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CIRCLE THE SYMPTOMS:

Breathing: coughing wheezing breathing fast difficulty breathing other _____________

Skin: pale flushed rash sores swelling bruised itchiness other _______________

Vomiting (# times) ___________ Diarrhea (# times) ___________ other ______________

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: __________ Circle one: auxiliary 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: ____

Signature: ____