

**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: \_\_\_\_\_  
\_\_\_\_\_

**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: \_\_\_\_\_