



Health & Safety Form



Suspected Illness or Communicable Disease

NAME OF CHILD _____

FACILITY _____ DATE _____

Dear Parent or Legal Guardian:

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

- | | |
|--|--|
| <input type="checkbox"/> Diarrhea (more than one abnormally loose stool) | <input type="checkbox"/> Child makes a high-pitched croupy or whooping sound after s/he coughs |
| <input type="checkbox"/> Difficult or rapid breathing | <input type="checkbox"/> Severe itching of body/scalp |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Sore throat or trouble swallowing |
| <input type="checkbox"/> Fever (101° F or above orally) | <input type="checkbox"/> Unusual behavior |
| <input type="checkbox"/> Gray or white stool | <input type="checkbox"/> Child cries more than usual |
| <input type="checkbox"/> Headache and stiff neck | <input type="checkbox"/> Child feels general discomfort |
| <input type="checkbox"/> Infected skin patches | <input type="checkbox"/> Cranky or less active |
| <input type="checkbox"/> Crusty, bright yellow, dry or gummy areas of skin | <input type="checkbox"/> Just seems unwell |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Unusual spots or rashes |
| <input type="checkbox"/> Pink eye | <input type="checkbox"/> Unusually dark, tea-colored urine |
| <input type="checkbox"/> Tears, redness of eyelid lining | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Irritation | <input type="checkbox"/> Yellow skin or eyes |
| <input type="checkbox"/> Swelling and/or discharge of pus | <input type="checkbox"/> Head lice or nits |
| <input type="checkbox"/> Severe coughing | |
| <input type="checkbox"/> Child gets red or blue in the face | |

Contact your health care provider if there is:

- | | |
|--|--|
| <input type="checkbox"/> Persistent fever (over 100° F) without other symptoms | <input type="checkbox"/> Yellow skin and/or eyes |
| <input type="checkbox"/> Breathing so hard he cannot play, talk, cry or drink | <input type="checkbox"/> Unusual confusion |
| <input type="checkbox"/> Severe coughing | <input type="checkbox"/> Rash, hives or welts that appear quickly |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Severe stomach ache that causes the child to double up and scream |
| <input type="checkbox"/> Sore throat with fever | <input type="checkbox"/> No urination over an 8 hour period; the mouth and tongue look dry |
| <input type="checkbox"/> Thick nasal drainage | <input type="checkbox"/> Black stool or blood mixed with the stool |
| <input type="checkbox"/> Rash accompanied by fever | <input type="checkbox"/> Any child who looks or acts very ill or seems to be getting worse quickly |
| <input type="checkbox"/> Persistent diarrhea | |
| <input type="checkbox"/> Severe headache and stiff neck with fever | |

We are excluding your child from attendance at our program until (possible options):

- | | |
|---|--|
| <input type="checkbox"/> The signs or symptoms are gone | <input type="checkbox"/> We can provide the level of care your child needs |
| <input type="checkbox"/> The child can comfortably participate in the program | <input type="checkbox"/> Other: _____ |