Parent – Medical FYI

Child Care Center _____ Date _____

Child Name _____ Date of Birth_____

Dear Parent,

Today we noticed the following

Symptoms:

(Circle all that apply; Describe details in space below)

Behavior Change	Fever	Pain	Trouble Breathing
Cough	Headache	Rash	Trouble Sleeping
Crying	Itching	Runny Nose	Trouble Urinating
Diarrhea	Lethargic (very sleepy)	Skin Sores	Vomiting
Drainage	Mouth Sores	Sore Throat	Wheezing
Earache	Not Eating	Stomachache	

Details: (Temperature, how taken, frequency of symptom, when started, how long lasted, color and amount of fluid/drainage, (thick, green, white, clear, bloody) change in behavior,etc.)

How long have we noticed these symptoms?

Please take the following action:

☐ Carefully watch your child for further symptoms of illness
Refer to your parent handbook for guidelines on when to keep your child home
Refer medical questions to your child's doctor

☐ Other _____

Sincerely,

_____ _____
Staff completing form Phone Number at Center

orig-parent
cc-child care center