DAILY HEALTH CHECK

Year _____

Child's Name _____ Date of Birth _____ Child Care Program _____

KEY:
A: Absent **B:** Bruise **C:** Crusty Eyes **CS:** Cuts/Scrapes **D:** Diarrhea **E:** Earache **F:** Feverish **FC:** Flushed Complexion
G: Glazed Eyes **H:** Headache **HA:** Hyperactive **HL:** Head Lice **I:** Irritable **L:** Listless **M:** Mild Cough **N:** Nasal Discharge
OK: Okay **OS:** Open Sores **P:** Pale **R:** Rash **S:** Sleepy **SC:** Severe Cough **ST:** Sore Throat **V:** Vomiting
W: Wheezing

(**NOTE:** If the following categories are noted – **B, CS, OS** or **R** – further details, including location on the body, should be noted in child's individual file)

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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