DAILY HEALTH CHECK FOR HEAD START CENTERS

Do the daily health check when you greet each child and parent as they arrive. It usually takes less than a minute. Also observe the child throughout the day.

LISTEN: Greet the child and parent. Ask the child, "How are you today?" Ask the parent, "How are you doing? How's (name of child)?" "Was there anything different last night?" "How did he sleep?" "How was her appetite this morning?"

- Listen to what the child and parent tell you about how the child is feeling.
- If the child can talk, is he complaining of anything? Is he hoarse or wheezing?

LOOK: Get down to the child's level to see her clearly. Observe signs of health or illness.

- General appearance (e.g., comfort, mood, behavior, and activity level)
  - Is the child's behavior unusual for this time of day?
  - Is the child clinging to the parent, acting cranky, crying, or fussing?
  - Does she appear listless, in pain, or have difficulty moving?

- Breathing
  - Is the child coughing, breathing fast, or having difficulty breathing?

- Skin
  - Does the child look pale or flushed?
  - Do you see a rash, sores, swelling, or bruising?
  - Is the child scratching her skin or scalp?

- Eyes, Nose, Ears, Mouth
  - Do the child's eyes look red, crusty, goopy, or watery?
  - Is there a runny nose?
  - Is he pulling at his ears?
  - Are there mouth sores, excessive drooling, or difficulty swallowing?

FEEL: Gently run the back of your hand over the child's cheek, forehead, or neck.

- Does the child feel unusually warm or cold and clammy?
- Does the skin feel bumpy?

SMELL: Be aware of unusual odors.

- Does the child's breath smell foul or fruity?
- Is there an unusual or foul smell to the child's stools?

Symptom Record

Child's name: ______________________________________ Date: ____________________

MAIN SYMPTOM ________________________________________________________________

When it began ____________________________ How long it lasted _____________________

How much _______________________________ How often ___________________________

Staying constant, getting better or worse? __________________________________________

OTHER SYMPTOMS: Complaints ___________________________________________________

General appearance (e.g., comfort, mood, behavior, activity level, appetite)

CIRCLE THE SYMPTOMS:

Breathing: coughing  wheezing  breathing fast  difficulty breathing  other _______________________

Skin: pale  flushed  rash  sores  swelling  bruises  itchiness  other ____________________________

Vomiting: (# times) ____________ Diarrhea (# times) ____________ Urine ________________

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: ________________ (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 (e.g., parent/guardian, emergency contact person, health consultant, child's health provider, emergency medical services):

Signature _______________________________________________________________________