Daily Health Check of Children

(Taken from: http://www.bmcc.edu/Headstart/Trngds/Diseases/pg91-108.htm)

Child care staff and early childhood providers should conduct daily health checks when greeting each child and parent as they arrive. The daily health check does not take long and will provide useful information regarding whether a child is ill. Child care staff and early childhood providers should 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 him/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, dying, 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 has 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*_________

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:____