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 s/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 s/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 chlld'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?

From: *Keeping Kids Healthy.* Sacramento, CA: California Dept. of Education, 1994.

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 of person completing form _____ Date _____

Adapted from: Model Child Care Health Policies, American Academy of Pediatrics, Pennsylvania Chapter, 1193, and Healthy Young Children: A Manual for Programs, National Association for the Education of Young Children, 1995.