

# REQUEST FOR HEALTH CARE PROVIDER EVALUATION

PROGRAM \_\_\_\_\_

CONTACT PERSON \_\_\_\_\_

TELEPHONE # \_\_\_\_\_ DATE \_\_\_\_\_

## TO BE COMPLETED BY CHILD CARE PROVIDER

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The following signs and/or symptoms have been noted:

- Wheezing
- Severe or Uncontrollable Cough
- Cold, Runny Nose – severe congestion that interferes with normal activity
- Diarrhea
- Eye Drainage
- Fever \_\_\_\_\_
- Irritability / Inconsolable or Continuous Crying
- Mouth Sores
- Pain
- Rash
- Seizure
- Skin Sores
- Sore Throat
- Vomiting
- White or Grey Stool
- Yellow Skin or Eyes
- Other Concerns or Observations: \_\_\_\_\_

- Cases of \_\_\_\_\_ have recently been reported in other children attending our program.

## HEALTH CARE PROVIDER – Please evaluate this child and complete the information below.

### DIAGNOSIS:

- Communicable If YES, what is the diagnosis? \_\_\_\_\_
- Not Communicable **TREATMENT:** \_\_\_\_\_
- No Treatment Necessary
- Treatment Recommended \_\_\_\_\_

- Duration of Treatment \_\_\_\_\_ **CAN CHILD RETURN TO CHILD CARE NOW?**  Yes  No If no, when can child return? \_\_\_\_\_

Comments: \_\_\_\_\_

HEALTH CARE PROVIDER SIGNATURE: \_\_\_\_\_

PHONE # \_\_\_\_\_ DATE: \_\_\_\_\_

Parent or Guardian, please return this completed form to the child care provider when the child returns. Thank You.