

ILLNESS RECORD

This record should be completed as soon as practicable, but no later than 12 hours after the incident, injury or trauma.

NAME OF CHILD: _____ DOB: ____ / ____ / ____

DATE OF APPARENT ONSET OF ILLNESS: ____ / ____ / ____ TIME: _____ am/pm

RELEVANT CIRCUMSTANCES SURROUNDING THE CHILD BECOMING ILL:

APPARENT SYMPTOMS:

ACTION TAKEN BY STAFF (INCLUDING FIRST AID, MEDICAL PERSONNEL NOTIFIED):

PERSONS NOTIFIED OR ATTEMPTED TO BE NOTIFIED:

1.	Name: _____	Date: ____ / ____ / ____
		Time: _____ am/pm
2.	Name: _____	Date: ____ / ____ / ____
		Time: _____ am/pm
3.	Name: _____	Date: ____ / ____ / ____
		Time: _____ am/pm

FORM COMPLETED BY:

Name: _____	Signature: _____
Name: _____	Time: _____

Parent Signature: _____ Date: _____ Time: _____