COLORADO
Department of Public Health & Environment

ILLNESS LOG

Child Care Facility Name: _____ **Contact Person:** _____ **Phone #:** _____

NAME	STUDENT	STAFF	CLASS/ GROUP and/or STAFF POSITION	ONSET DATE & TIME	Vomit	Diarrhea	Cough	Runny Nose	Fever	OTHER SYMPTOMS*	DIAGNOSIS/ + or - TEST**	Symptoms while at school	Stayed home	TREATMENT/ACTION†	DATE & TIME RETURNED TO GROUP CARE

*** Symptoms:** **A** = Abdominal Cramps **BD** = Bloody Diarrhea **N** = Nausea **M** = Muscle Aches **C** = Chills **H** = Headache **R** = Rash

****Diagnosis or Test: I**f reported to facility by staff/ guardian, please share positive or negative test results and/or healthcare provider diagnosis

† **Treatment/Action:** For example--First aid; admininistered meds; sent home; excluded for 48 hours, **if reported hospitalized please include DOB.**

Reviewed by Person in Charge:_____ Date:_____