DAILY HEALTH CHECK

PROVIDER _____ **CHILD'S NAME** _____ **YEAR** _____

Key:

B: Bruise
L: Listless
A: Absent
F: Flushed Skin
NS: Nasal Discharge
G: Glazed Eyes
I: Irritable
P: Pale
OK: Okay
MC: Mild Cough
C: Crusty Eyes
OS: Open Sores
LP: Limp
SR: Skin Rash
S: Sleepy
BL: Bleeding
HL: Head Lice

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
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