Monthly Daily Health Check Record

MONTH and YEAR: _____

For each child, each day: Code Top Box = AB (absent) or O = well or use symptom numbers from bottom of the page; Code Bottom Box: AB (absent) or O = well or use symptom numbers from bottom of the page

CHILD'S NAME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

Symptom Codes

O = Well Child

1 General Mood/unusual behavior
2 Unusual skin color
3 Rash
4 Swelling or bruises
5 Sores/cuts
6 Respiratory: sore throat, cough sneezing, wheezing, running nose
7 Diarrhea
8 Mouth sores with drooling
9 Stomachache
10 Vomiting
11 Urine Problems
12 Headache
13 Fever
14 Eye drainage
15 Other

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MONTH and YEAR: _____

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CHILD'S NAME	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Symptom Codes

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