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HOME AWAY FROM HOME
ACADEMY
Carousel Corporation

"Leaders in Early Childhood Education"

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 & or symptoms have been noted:

- ☐ Cold, Runny Nose
- ☐ Cough/Wheezing
- ☐ 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

_____

_____ have recently been reported in other children attending our program.

HEALTH CARE PROVIDER, PLEASE EVALUATE THIS CHILD AND COMPLETE THIS FORM

DIAGNOSIS: ☐ Communicable If yes, what is the diagnosis? _____
☐ Not Communicable

TREATMENT: ☐ No Treatment Necessary
☐ Treatment Recommended

_____

☐ Duration _____

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.