701 Grand Ave., Asbury Park, N.J. * (732)775-1582 * Fax (732)775-6353

Request for Health Care Provider Evaluation

TO BE COMPLETED BY CHILD CARE PROVIDER

Child's Name: ____________________ Date: ____________

The following signs &/or symptoms have been noted:

__Wheezing
__Severe or Uncontrollable Cough
__Cold, Runny Nose – severe congestion that interferes with normal activity
__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

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__Cases of ____________________________ have recently been reported in other children attending our program.

HEALTH CARE PROVIDER, PLEASE EVALUATE AND COMPLETE 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 STAMP / PHONE / DATE

Parent/Guardian, please return completed form to child care provider when child returns.