KANAWHA CHARLESTON HEALTH DEPARTMENT

Childcare Center Influenza Screening Form

Complete this form for every child prior to admittance to the child care facility. An adult or caregiver must complete the screening questions and verify the information. Both the screener and the parent should sign the form.

Date of Screening _____

Child's name _____

Age: _____ **Sex** Male Female

Class: _____

Has your child been given Tylenol or Ibuprofen products in the last 4 hours? ☐ Yes ☐ No

Is your child currently exhibiting ANY of the following symptoms?

Cough	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Body Aches	☐ Yes	☐ No
Fatigue (Physical Exhaustion)	☐ Yes	☐ No
Runny or Stuffy nose	☐ Yes	☐ No
Nausea (Stomachache)	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No

Has your child had a fever or any of the above symptoms in the last 7 days? ☐ Yes ☐ No

If yes, what date did your child first become ill?_____

**A child with a fever of 99.5°F or greater and no other flu symptoms should be sent home for observation for 24 hours. After 24 hours, if child is symptom free and temperature is less than 100°F, he/she may return to school.*

Temperature _____

RECORDED BY SCREENER

_____ _____

Signature of the person completing the form **Signature of screener**

Relationship to the child of the person completing form _____