



Day Care Monthly Illness Report Form Instructions



INSTRUCTIONS: Fill out this form even if there are no new admissions, no enrollees leaving the center, or no absences—check the boxes indicating this in each section. Report only **1** month on each form. Mark answers with only **1** check mark, unless instructed otherwise; if the information is unknown, mark “D/K” for Don’t Know. Make a new entry each time a child is absent due to illness or accident. Use additional sheets as necessary. This form can be found on the Cleveland Department of Health website at: <http://www.clevelandhealth.org/Health/NursingServices/DayCareIllnessReporting.html>.

1. For new admissions, give complete information regarding name, age, gender, and the name of the former day care center.
2. For enrollees leaving the center, provide the name, age, gender, and last date of enrollment. Indicate whether the child transferred to another center or was ill at the time of departure.
3. For all absences due to illnesses or accidents, document the child’s name, age, gender, and classroom. Check all boxes that apply for the type of illness or accident using the provided categories. If the child’s illness or accident is not listed in the categories, check “7” for other and write or type in the information. Specify whether the child was seen by a doctor for the problem, and give the dates of absence(s).
4. Provide information of the person submitting the form, the director of the facility, and the date of the report.

Mail, fax, or e-mail this form on **the first Monday of each month** to:

Cleveland Department of Public Health
Division of Nursing – Daycare Unit
75 Erieview Plaza, 3rd Floor
Cleveland, Ohio 44114
Phone: (216) 664-3609
Fax: (216) 664-6159
E-mail: DayCareUnit@city.cleveland.oh.us

Day Care Monthly Illness Report Form



Name of Facility: _____ **Address:** _____
Report Month: January February March April May June July August September October November December

New Admissions: _____ No New Admissions

Last Name	First Name	Age	Gender (Male/Female)	Date of Admission (__ / __ / __)	Name of Former Day Care Center
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		

Enrollees Leaving the Center: _____ No Enrollees Leaving the Center

Last Name	First Name	Age	Gender (Male/Female)	Last Date of Enrollment (__ / __ / __)	Did the child transfer to another center? (Yes/No/Don't Know)	Any illnesses at time of departure? (Yes/No/Don't Know)
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K

Day Care Monthly Illness Report Form

Name of Facility: _____ Address: _____
 Report Month: January February March April May June July August September October November December

Absences: No Absences

Last Name	First Name	Age	Gender	Classroom	Type of Illness/ Accident	Did the child see a doctor for the problem? (Yes/No/Don't Know)	Date(s) Absent (__/__/__) -- (__/__/__)
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	
-----			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> D/K	

Name of Person Reporting: _____

Name of Director: _____

Date: _____

Mail, fax, or e-mail form to:

Cleveland Department of Public Health
 Division of Nursing – Daycare Unit
 75 Erieview Plaza, 3rd Floor
 Cleveland, OH 44114
 Phone: (216) 664-3609
 Fax: (216) 664-6159
 E-mail: DayCareUnit@city.cleveland.oh.us

Type of Illness/Accident:

1 = Cold, cough, fever, sore throat, upper respiratory infection; 2 = Ear infection; 3 = Vomiting, diarrhea, stomach ache; 4 = Injury or accident; 5 = Rash;
 6 = Hospitalized; 7 = Other