Region of Peel
working with you

ILLNESS TRACKING FORM

Child Care Centre: _____ Room: _____

Total # of children in room: _____

Total # of staff in room: _____

CASE IDENTIFICATION			SYMPTOMS											OUTCOME		
Date	Child/Staff Initials	S=Staff C=Child	First date of symptoms (dd/mm/yyyy)	Fever >37.8	Chills	Headache	Diarrhea	Vomiting	Nausea	Cough	Sore throat	Runny nose/Nasal congestion			Other symptoms & comments e.g. loss of appetite, fatigue, eye discharge, rash, COVID positive	Last date a child/staff attended the childcare centre	Date of return
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