

Caring for Our Children, National Health and Safety Performance Standards:  
Source: Guidelines for Out-of-Home Child Care Programs 2<sup>nd</sup> Edition 2002

**Modified for Iowa Foster Care**

**If you choose to implement a daily health check follow the recommendations below.**

**STANDARD 3.001 - Daily Health Check<sup>1</sup>**

Every day, a trained staff member shall conduct a health check of each child. This health check shall be conducted as soon as possible when the child enters the facility and whenever a placement or room change occurs while that child is in care.

The facility shall gain information necessary to complete the daily health check by direct observation of the child and, where applicable, by conversation with the child.

RATIONALE: Daily procedures to appraise a child's health and to ascertain recent illness or injury aids in reducing the spread of communicable diseases in foster care settings and enables caregivers to plan for necessary care while the child is in foster care.

COMMENTS: This assessment should be performed in a relaxed and comfortable manner that respects the child's culture as well as the child's body and emotions including the need for privacy. Assessment of a child's overall health status by querying the parent or Iowa Department of Human Services foster care contact should occur at the time of transitioning the child to the foster care facility.

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**Know the symptoms of influenza.**

The symptoms of influenza include

- Fever (100 degrees orally Fahrenheit or above)
- Cough
- Sore throat
- Runny or stuffy nose
- Body aches
- Headache
- Feeling very tired.

Some people may vomit or have diarrhea.

**STANDARD 3.002 - Documentation of the Daily Health Check<sup>1</sup>**

The facility shall keep, for at least 3 months, a written record of concerns it identifies for each child during the daily health checks.

RATIONALE: Although the vast majority of communicable diseases of concern have incubation periods of less than 21 days, lags in reporting, non-apparent infections, and the slow-to-develop nature of some outbreaks suggest keeping data for 3 months.

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<sup>1</sup> Modified from the American Academy of Pediatrics, 2002. Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs 2<sup>nd</sup> Edition. Elk Grove, IL.

**Daily Health Check**

Instructions: Conduct a daily health check of each child. This health check should be conducted as soon as possible each morning and upon arrival from child care, school, or work. Staff should collect information needed to complete the health check by direct observation of the child and by talking with the child. Place a checkmark ✓ in the box to the left of the description of symptom and circle items found

**Child Name:** \_\_\_\_\_ **Date** \_\_\_\_\_

<b>Change in appearance or body function</b>	
<input type="checkbox"/>	Hair, Finger & Toe nails
<input type="checkbox"/>	Head, headache
<input type="checkbox"/>	Eyes & Vision
<input type="checkbox"/>	Ears & Hearing
<input type="checkbox"/>	Nose, runny, stuffy nose, or altered sense of smell
<input type="checkbox"/>	Mouth, tongue, teeth, drooling
<input type="checkbox"/>	Throat, difficulty swallowing, breathe odor
<input type="checkbox"/>	Neck, stiff neck, unable to fully move neck
<input type="checkbox"/>	Skin, any bluish color around mouth, nose, lips
<input type="checkbox"/>	Hives, rash, itchy skin, itchy scalp, head lice, open sores, red blotches, or red-cheeked
<input type="checkbox"/>	Open skin sore(s) with drainage
<input type="checkbox"/>	Skin feels warm and dry
<input type="checkbox"/>	Skin feels warm with sweating
<input type="checkbox"/>	Chest & breathing problem, cough
<input type="checkbox"/>	Heart & Pulse
<input type="checkbox"/>	Stomach & Abdomen
<input type="checkbox"/>	Eating & Appetite
<input type="checkbox"/>	Vomiting, spitting up
<input type="checkbox"/>	Bathroom Use
<input type="checkbox"/>	Bowel Movements, diarrhea, loose stools, constipation Number of stools _____
<input type="checkbox"/>	Urine color or odor change Number of wet diapers or urination _____
<input type="checkbox"/>	Arms & Hands appearance, color, cool or warm to touch, swelling
<input type="checkbox"/>	Legs & Feet appearance, color, cool or warm to touch, swelling
<input type="checkbox"/>	Fever, Temperature _____ <input type="checkbox"/> oral, <input type="checkbox"/> axillary, <input type="checkbox"/> other method
<input type="checkbox"/>	Pain or body ache
<input type="checkbox"/>	Complains, not feeling well;
<input type="checkbox"/>	Ill room-mate or family member

<b>Change in behavior</b>	
<input type="checkbox"/>	Behavior change from earlier today
<input type="checkbox"/>	Behavior change from yesterday
<input type="checkbox"/>	Crying, fussy, whining, or complaints of feeling ill.
<input type="checkbox"/>	Drowsy, hard to awake child
<input type="checkbox"/>	Quiet, more quiet than usual
<input type="checkbox"/>	Sleeping more than usual
<input type="checkbox"/>	Tired but not sleeping
<input type="checkbox"/>	Mood: Bossy, Grumpy, Grouchy, or Bullying
<b>Injury</b>	
<input type="checkbox"/>	<b>Injury at foster care</b>  <input type="checkbox"/> Injury/Incident Report filed on <u>date</u>
<input type="checkbox"/>	<b>Injury away from foster care</b> <u>date</u>  <input type="checkbox"/> Injury/Incident Report filed by: <u>Date</u>
<b>Child's self report of how they feel.</b>	

**Other Symptoms/Concerns:**

Foster Care Staff Member (signature) \_\_\_\_\_