FCSS Family and Community Support Services
Lamont County Region

Illness Form

Provider's name: _____

Child's name: _____

Date child observed ill: _____

Symptoms observed:

_____
_____
_____
_____
_____

Time parent contacted: _____

Name of individual who contacted parent: _____

Time child removed from program: _____

Evidence received to ensure child can be returned to program:

_____
_____
_____
_____

Date child returned to provider residence: _____

Other:

_____
_____
_____

Alberta Approved Family Day Homes