

Enrolment date \_\_\_/\_\_\_/\_\_\_ Child's Initials \_\_\_ Weight this week \_\_\_ kg Date weighed \_\_\_/\_\_\_/\_\_\_  <6m

Month ___ Date	___	___	___	___	___	___	___
(24h clock) Time seen	___:___	___:___	___:___	___:___	___:___	___:___	___:___
Oedema now	+++ ++ + N	+++ ++ + N	+++ ++ + N	+++ ++ + N	+++ ++ + N	+++ ++ + N	+++ ++ + N
Oedema improving?	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
For infants under 6m Weigh 48hrly	___ kg	___ kg	___ kg	___ kg	___ kg	___ kg	___ kg

Clinical Events in the last 24h

<b>DANGER SIGNS</b> at any time in last 24h? If any new danger signs take bloods and record these in sample log. If bloods have been taken by clinical team document results, do not retake bloods	Obstructed breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Respiratory distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cyanosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shock*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Severe anaemia*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Convulsion(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Severe Dehydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Profuse watery Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vomits everything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Impaired Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NO DANGER SIGNS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Temperature >38°C in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Temperature <36°C in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
NG tube in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Any EBM or breastfeeding last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
ReSoMal in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
ORS in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
IV fluids given in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Blood transfusion in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Oxygen given in last 24h?	Y N	Y N	Y N	Y N	Y N	Y N	Y N
CPAP given in last 24h?	Y N	Y N	Y N	Y N	Y N	Y N	Y N

Clinical Observations now

In oxygen now	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Oxygen saturation now	___%	___%	___%	___%	___%	___%	___%
Respiratory rate now	___/min	___/min	___/min	___/min	___/min	___/min	___/min
Heart rate now	___/min	___/min	___/min	___/min	___/min	___/min	___/min
AVPU now (circle)	A V P U	A V P U	A V P U	A V P U	A V P U	A V P U	A V P U
Temperature now	___ °C	___ °C	___ °C	___ °C	___ °C	___ °C	___ °C
In PICU/ HDU now	Y N	Y N	Y N	Y N	Y N	Y N	Y N
In a surgical or specialist unit now	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Currently on F75/equivalent	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Currently on F100/equivalent	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Currently on RUTF	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Currently on supplementary feed	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Infant formula or dilute F100	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Non-standard milk e.g. soya	Y N	Y N	Y N	Y N	Y N	Y N	Y N



Month ___ ___ Date	___	___	___	___	___	___	___
Currently has an IV cannula?	Y N	Y N	Y N	Y N	Y N	Y N	Y N
<b>IV ANTIMICROBIALS IN LAST 24H</b>							
Crystalline / benzylpenicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gentamicin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ceftriaxone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ampicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e.g. augmentin) Co-Amoxiclav	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chloramphenicol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cefotaxime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ceftazidime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flucloxacilin/Cloxacillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meropenem/Imipenem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pivmecillinam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NO IV ANTIBIOTICS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>ORAL ANTIBIOTICS IN LAST 24H</b>							
Oral Amoxicillin/ampiclox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e.g. augmentin) Co-Amoxiclav	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Azithromycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Cephalosporin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Co-trimoxazole <u>treatment</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Co-trimoxazole <u>prophylaxis</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nitrofurantoin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nalidixic acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clindamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metronidazole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pivmecillinam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NO ORAL ANTIBIOTICS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>OTHER ANTI-INFECTIVE AGENTS IN LAST 24H</b>							
Anti-malarial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ART	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e.g. fluconazole) Antifungal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-TB treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinician's initials							

