

Child Initials

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F	1	2	7	5
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Date of Enrolment	Complete this record every day during the child's index admission, circle responses						
___/___/___ D D / M M / Y Y Y Y							
Month ___ Date	___ (E1)	___ (E2)	___ (E3)	___ (E4)	___ (E5)	___ (E6)	___ (E7)
(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
Weight	___	___	___	___	___	___	___
MUAC	___	___	___	___	___	___	___
CLINICAL EVENTS IN THE LAST 24H							
Obstructed breathing	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Respiratory distress in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Cyanosis/ SaO <sub>2</sub> <90% 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
Shock* in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Severe anaemia* in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Convulsion(s) in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Severe Dehydration in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Profuse watery Diarrhoea in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Vomits everything in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Impaired Consciousness in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
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 in 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 given in last 24h	Y N	Y N	Y N	Y N	Y N	Y N	Y N
CLINICAL OBSERVATIONS NOW							
On 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
Axillary Temperature now	___ °C	___ °C	___ °C	___ °C	___ °C	___ °C	___ °C
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
CURRENT CARE							
In PICU/HDU	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
Infant formula or diluted F100	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
On another Therapeutic feed	Y N	Y N	Y N	Y N	Y N	Y N	Y N
On a Supplementary feed	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Clinician's initials	___	___	___	___	___	___	___
Data entered by(initials)	___ (E1)	___ (E2)	___ (E3)	___ (E4)	___ (E5)	___ (E6)	___ (E7)

NOW RECORD TODAY'S ANTIBIOTIC TREATMENTS ON THE NEXT PAGE

Severe anaemia = haemoglobin <4g/dL or respiratory distress and haemoglobin <6g/dL.

Shock = cool peripheries, fast weak pulse and capillary refill time >2

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<b>Date of Enrolment</b>	___/___/___		DD / MM / YYYY				
<b>Month ___ Date</b>	___ (E1)	___ (E2)	___ (E3)	___ (E4)	___ (E5)	___ (E6)	___ (E7)
<b>Currently has an IV cannula?</b>	Y N	Y N	Y N	Y N	Y N	Y N	Y N
<b>RANDOMISED ANTIMICROBIALS IN LAST 24H (NUMBER OF DOSES)</b>							
<b>Penicillin doses</b>	6 5 4 3 2 1 0	6 5 4 3 2 1 0	6 5 4 3 2 1 0	6 5 4 3 2 1 0	6 5 4 3 2 1 0	6 5 4 3 2 1 0	6 5 4 3 2 1 0
<b>Gentamicin doses</b>	2 1 0	2 1 0	2 1 0	2 1 0	2 1 0	2 1 0	2 1 0
<b>Ceftriaxone doses</b>	4 3 2 1 0	4 3 2 1 0	4 3 2 1 0	4 3 2 1 0	4 3 2 1 0	4 3 2 1 0	4 3 2 1 0
<b>Metronidazole/Placebo doses</b>	4 3 2 1 0	4 3 2 1 0	4 3 2 1 0	4 3 2 1 0	4 3 2 1 0	4 3 2 1 0	4 3 2 1 0
<b>OTHER NON-RANDOMISED IV ANTIMICROBIALS IN LAST 24H</b>							
<b>Ampicillin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Amikacin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ciprofloxacin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>(e.g. augmentin) Co-Amoxiclav</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Chloramphenicol</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cefotaxime</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ceftazidime</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Clindamycin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Flucloxacillin/Cloxacillin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ceftriaxone NON-RANDOMISED</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>*Other _____</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>*Other _____</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NO OTHER IV ANTIBIOTICS</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>OTHER NON-RANDOMISED ORAL ANTIMICROBIALS IN LAST 24H</b>							
<b>Oral Amoxicillin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>(e.g. augmentin) Co-Amoxiclav</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ciprofloxacin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Erythromycin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Azithromycin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Oral Cephalosporin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Co-trimoxazole <u>treatment</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Co-trimoxazole <u>prophylaxis</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nitrofurantoin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nalidixic acid</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Clindamycin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Metronidazole (open label)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>*Other _____</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>*Other _____</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NO OTHER ORAL ANTIBIOTICS</b>	<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>							
<b>Anti-malarial</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ART</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>(e.g. fluconazole) Antifungal</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Anti-TB treatment</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>(e.g. acyclovir) Antivirals</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NO OTHER ANTI-INFECTIVE DRUGS</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Clinician's initials</b>	___	___	___	___	___	___	___
<b>Data entered by(initials)</b>	___ (E1)	___ (E2)	___ (E3)	___ (E4)	___ (E5)	___ (E6)	___ (E7)

\* Use official drug names, not generic or trade names.