

## IM5 Clinical Worksheet – Pediatric Floor

<p><b>Student Name:</b> Brittany Fox  <b>Date:</b> 10/1/25</p>	<p><b>Patient Age:</b> 8yo  <b>Patient Weight:</b> 26 kg</p>
<p><b>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</b>          Sickle cell disease is a mutation in of the hemoglobin gene. It causes the cell to become crescent shaped and difficult to pass through vessels. This cuts off blood &amp; O<sub>2</sub> supply causing severe pain.</p>	<p><b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b>          pain assessment</p>
<p><b>3. Identify the most likely and worst possible complications.</b>          vaso-occlusive crises          chronic anemia          leg ulcers          acute chest syndrome          hepatomegaly          splenomegaly</p>	<p><b>4. What interventions can prevent the listed complications from developing?</b>          avoid strenuous activities          stay up to date on immunizations          avoid being around sick people          keep hydrated</p>
<p><b>5. What clinical data/assessments are needed to identify these complications early?</b>          pain scale &amp; O<sub>2</sub> saturation          hx of triggers          CBC          creatinine &amp; BUN          assess skin color, s/s infection, urine, neuro</p>	<p><b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b>          provide hydration - replace electrolytes          analgesics          warm compresses          hydroxyurea</p>
<p><b>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b></p> <p>1. play games / draw art</p> <p>2. warm compresses &amp; get comfortable positions</p>	<p><b>8. Patient/Caregiver Teaching:</b></p> <p>1. Drink plenty of fluids to stay hydrated</p> <p>2. Avoid triggers (high altitudes, cold environments, stress)</p> <p>3. stay up to date on immunizations &amp; good handwashing to prevent infections</p> <p><b>Any Safety Issues identified:</b>          N/A</p>

<b>Student Name:</b> Brittany Fox	<b>Patient Age:</b> 8y0
<b>Date:</b> 10/1/25	<b>Patient Weight:</b> 26 kg

Abnormal Relevant Lab Tests	Current	Clinical Significance
<b>Complete Blood Count (CBC) Labs</b>		
NA		
<b>Metabolic Panel Labs</b>		
NA		
<b>Misc. Labs</b>		
<b>Absolute Neutrophil Count (ANC) (if applicable)</b>		
NA		
<b>Lab TRENDS concerning to Nurse?</b>		
NA		

**11. Growth & Development:**  
**\*List the Developmental Stage of Your Patient For Each Theorist Below.**  
**\*Document 2 OBSERVED Developmental Behaviors for Each Theorist.**  
**\*If Developmentally Delayed, Identify the Stage You Would Classify the Patient:**

**Erickson Stage:** Industry vs. Inferiority

- Hesitant to play a game
- Shows off artwork to staff and parents

**Piaget Stage:** Concrete Operational

- Knows that splitting a chocolate bar doesn't make it more
- Arranged sticks from shortest to longest

**Please list any medications you administered or procedures you performed during your shift:**  
 Acetaminophen and Morphine

### Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ <b>Edema:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R <u>3+</u> L <u>3+</u> Lower R <u>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>4</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>5</u> Left <u>5</u> Pushes: Right <u>5</u> Left <u>5</u> S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Urine Appearance:</b> <u>not observed</u> <b>Stool Appearance:</b> <u>not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>Site:</b> _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> _____
RESPIRATORY	GASTROINTESTINAL	SKIN
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>index</u> <b>Oxygen Saturation:</b> <u>97%</u>	<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input checked="" type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <u>4</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: _____ <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	<b>Diet/Formula:</b> <u>regular</u> <b>Amount/Schedule:</b> _____ <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> <u>everywhere</u> <b>Type:</b> <u>sharp</u> <b>Pain Score:</b> <u>7/10</u> 0800 <u>7</u> 1200 _____ 1600 _____
	MUSCULOSKELETAL	WOUND/INCISION
	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors <b>Movement:</b> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All <b>Brace/Appliances:</b> <input checked="" type="checkbox"/> None Type: _____	<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____
	MOBILITY	TUBES/DRAINS
	<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

**Pediatric Floor Patient #1**

INTAKE/OUTPUT													
<b>PO/Enteral Intake</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed													
Intake – PO Meds													
<b>IV INTAKE</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
<b>Calculate Maintenance Fluid Requirement (Show Work)</b>							<b>Actual Pt IV Rate</b>						
$10 \times 100 = 1000$ $10 \times 50 = 500$ $6 \times 20 = 120$ $\hline 1620$							$\frac{1620}{24} = 67.5 \rightarrow 68 \text{ mL/hr}$						
							<b>Rationale for Discrepancy (if applicable)</b>						
<b>OUTPUT</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper													
Stool													
Emesis													
Other													
<b>Calculate Minimum Acceptable Urine Output</b>							<b>Average Urine Output During Your Shift</b>						
$26 \text{ kg} \times 0.5 = 13 \text{ mL/hr}$													

Children's Hospital Early Warning Score (CHEWS)	
(See CHEWS Scoring and Escalation Algorithm to score each category)	
Behavior/Neuro	Circle the appropriate score for this category: <input checked="" type="radio"/> 0    1    2    3
Cardiovascular	Circle the appropriate score for this category: <input checked="" type="radio"/> 0    1    2    3
Respiratory	Circle the appropriate score for this category: <input checked="" type="radio"/> 0    1    2    3
Staff Concern	1 pt – Concerned
Family Concern	1 pt – Concerned or absent
<b>CHEWS Total Score</b>	
CHEWS Total Score	Total Score (points) <u>0</u>
	Score 0-2 (Green) – Continue routine assessments
	Score 3-4 (Yellow) – Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) – Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications

## IM5 Clinical Worksheet – Pediatric Floor

<p><b>Student Name:</b> Brittany Fox <b>Date:</b> 10/1/25</p>	<p><b>Patient Age:</b> 13 <b>Patient Weight:</b> 46 kg</p>
<p><b>1. Admitting Diagnosis and Pathophysiology (State the pathophysiology in own words)</b>                  following a strep infection, immune complexes are deposited into the glomeruli. The inflammation causes damage + leads to ↑ hematuria + proteinuria in equal amounts. Damage also caused fluid + Na retention leading to edema + HTN.</p>	<p><b>2. Priority Focused Assessment You Will Perform Related to the Diagnosis:</b>                  fluid balance and urinary assessment</p>
<p><b>3. Identify the most likely and worst possible complications.</b>                  HTN                  edema / fluid overload                  oliguria                  electrolyte imbalances                  AKI</p>	<p><b>4. What interventions can prevent the listed complications from developing?</b>                  frequent BP checks                  daily weights to track fluid retention                  Na + fluid restriction                  adequate rest                  balanced diet - possible K<sup>+</sup> restriction</p>
<p><b>5. What clinical data/assessments are needed to identify these complications early?</b>                  blood pressure for HTN                  urine color + proteinuria + hematuria                  ASO titer                  look for edema                  check if BUN + creatinine is elevated</p>	<p><b>6. What nursing interventions will the nurse implement if the anticipated complication develops?</b>                  monitor VS                  strict I + O's                  daily weight                  monitor for dehydration                  allow rest periods</p>
<p><b>7. Pain &amp; Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain &amp; Discomfort for This Patient.</b></p> <p>1. have them read or play games on a phone for distraction</p> <p>2. let them choose a comfortable position using pillows + warm compresses</p>	<p><b>8. Patient/Caregiver Teaching:</b></p> <ol style="list-style-type: none"> <li>1. teach them to limit sodium intake and to not use added salt or salt substitutes</li> <li>2. avoid strenuous activities such as sports + allow the pt to frequently rest</li> <li>3. monitor the child's weight to check for fluid status / overload</li> </ol> <p><b>Any Safety Issues identified:</b>                  NA</p>

<b>Student Name:</b> Brittany Fox	<b>Patient Age:</b> 13
<b>Date:</b> 10/1/25	<b>Patient Weight:</b> 46 kg

Abnormal Relevant Lab Tests	Current	Clinical Significance
<b>Complete Blood Count (CBC) Labs</b>		
NA		
<b>Metabolic Panel Labs</b>		
NA		
<b>Misc. Labs</b>		
<b>Absolute Neutrophil Count (ANC) (if applicable)</b>		
NA		
<b>Lab TRENDS concerning to Nurse?</b>		
NA		

**11. Growth & Development:**

**\*List the Developmental Stage of Your Patient For Each Theorist Below.**

**\*Document 2 OBSERVED Developmental Behaviors for Each Theorist.**

**\*If Developmentally Delayed, Identify the Stage You Would Classify the Patient:**

**Erickson Stage:** Identity v. role confusion

1. Tried sketching instead of painting
2. Asking questions about medical care and wanting to make decisions

**Piaget Stage:** Formal operational

1. asks about their friends and school
2. asks why they are needing tests and medications

**Please list any medications you administered or procedures you performed during your shift:**

Furosemide and captopril

**Pediatric Floor Patient #1**

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	<b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ <b>Edema:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec	<b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious <b>Social/emotional bonding with family:</b> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	IV ACCESS	
<b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive <b>Oriented to:</b> <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age <b>Pupil Response:</b> <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>3</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <b>Extremities:</b> <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically <b>Grips:</b> Right <u>5</u> Left <u>5</u> <b>Pushes:</b> Right <u>5</u> Left <u>5</u> S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>Site:</b> _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: _____ <b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing Intact:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> _____	
RESPIRATORY	ELIMINATION	
<b>Respirations:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ <b>Trach:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color _____ Consistency _____ <b>Suction:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ <b>Pulse Ox Site:</b> <u>99%</u> <b>Oxygen Saturation:</b> <u>99%</u> <u>middle</u>	<b>Urine Appearance:</b> <u>not observed</u> <b>Stool Appearance:</b> <u>not observed</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	
RESPIRATORY	GASTROINTESTINAL	
<b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input checked="" type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <u>4</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Passing Flatus:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>Color:</b> <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: _____ <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration	
RESPIRATORY	PAIN	
RESPIRATORY	<b>Scale Used:</b> <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 <u>0</u> 1200 _____ 1600 _____	
RESPIRATORY	WOUND/INCISION	
RESPIRATORY	<input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____	
RESPIRATORY	TUBES/DRAINS	
RESPIRATORY	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____	

**Pediatric Floor Patient #1**

INTAKE/OUTPUT													
<b>PO/Enteral Intake</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake/Tube Feed													
Intake – PO Meds													
<b>IV INTAKE</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
<b>Calculate Maintenance Fluid Requirement (Show Work)</b>							<b>Actual Pt IV Rate</b>						
$10 \times 100 = 1000$ $10 \times 50 = 500$ $20 \times 20 = \frac{520}{2020}$							$\frac{2020}{24} = 84 \text{ mL/hr}$  <b>Rationale for Discrepancy (if applicable)</b>						
<b>OUTPUT</b>	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine/Diaper													
Stool													
Emesis													
Other													
<b>Calculate Minimum Acceptable Urine Output</b>							<b>Average Urine Output During Your Shift</b>						
$40 \times 0.5 = 23 \text{ mL/hr}$													

Children's Hospital Early Warning Score (CHEWS) (See CHEWS Scoring and Escalation Algorithm to score each category)	
Behavior/Neuro	Circle the appropriate score for this category: <input checked="" type="radio"/> 0    1    2    3
Cardiovascular	Circle the appropriate score for this category: <input checked="" type="radio"/> 0    1    2    3
Respiratory	Circle the appropriate score for this category: <input checked="" type="radio"/> 0    1    2    3
Staff Concern	1 pt – Concerned
Family Concern	1 pt – Concerned or absent
CHEWS Total Score	
<b>CHEWS Total Score</b>	Total Score (points) <input checked="" type="radio"/> 0
	Score 0-2 (Green) – Continue routine assessments
	Score 3-4 (Yellow) – Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) – Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications

Student Name: Brittany Fox

Unit: Pedi Floor

Pt. Initials: \_\_\_\_\_

Date: 10/1/25

**Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours**

Allergies: NKA

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
NA	Isotonic/ Hypotonic/ Hypertonic	NA	NA	NA

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?	IVP – List diluent solution, volume, and rate of administration  IVPB – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?			
				If not, why?			
Acetaminophen	analgesic	pain management	390mg PO Q6 PRN	yes	NA	N/V HA liver damage	<ol style="list-style-type: none"> <li>1. look for jaundice in eyes, dark urine, + abdominal pain</li> <li>2. do not exceed 75mg/kg/day</li> <li>3. don't use with other meds containing acetaminophen</li> <li>4. monitor for signs of allergic rxn (itching)</li> </ol>
Morphine	opioid	pain management	1.3mg <del>1mg</del> IVP Q4 PRN	yes	Normal saline <del>0.13mg/mL</del> 0.13mg/mL in 10mL over 3-5 min	respiratory depression drowsiness N/V constipation	<ol style="list-style-type: none"> <li>1. you will need to stay in bed for at least 30min after administration</li> <li>2. monitor for slow &amp; shallow breathing</li> <li>3. neuro check frequently for LOC</li> <li>4. ↑ fluids + fiber plus walk around to prevent constipation</li> </ol>
Furosemide	diuretic	reduce edema + fluid overload	40mg PO daily	yes	NA	hypokalemia dehydration hypotension ototoxicity	<ol style="list-style-type: none"> <li>1. watch for signs of dehydration (skin turgor, dry mucous membranes)</li> <li>2. monitor electrolytes (K<sup>+</sup>)</li> <li>3. monitor daily weights to check fluid status</li> <li>4. watch for muscle cramps, irregular heartbeat</li> </ol>
Captopril	anti-hypertensive ACE-inhibitor	control blood pressure	40mg PO daily	yes	NA	hypotension cough dizziness elevated K <sup>+</sup>	<ol style="list-style-type: none"> <li>1. take 1 hr before meal for best absorption</li> <li>2. limit K<sup>+</sup> in the diet</li> <li>3. notify me if you become light-headed + do not get out of bed on your own</li> <li>4. notify me immediately if a cough develops</li> </ol>
							<ol style="list-style-type: none"> <li>1. develops</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>