SOAP Note Template

Student Name: Mary Ella Spivey

Population (Geri/Adult/WH/Peds): Peds

Clinical Location: Covington Pediatrics

Preceptor: Christyl Hines, CRNP

Date of Patient Encounter: 09/21/2022

Patient Identifier (Initials/number): L.R.

Patient age/DOB: 3 years; 02/07/2019

Ethnicity and Gender: Caucasian; Female.

I. **Chief Complaint:** Her mother stated, "She doesn't appear like she feels well and had a fever yesterday and this morning."

II. **History of Present Illness:**

L.R. is a 3-year-old Caucasian female that presents to the clinic today with her mother. The patient is sitting in mom's lap hunched over hugging mom. Seems a little fearful of Nurse Practitioner and student. Patient ill-appearing with a fever yesterday morning and today before her appointment. The mother checked her fever on 9/20 in the morning and it was 102.3 temporal. Last night she checked her fever and it was 103 temporal. She stated her fever was on and off and was relieved with OTC Tylenol but seemed to return after the medication wore off. At today's appointment, the patient's temperature was 102.3. She has been treating the fever with OTC children's Tylenol 5 ML every 4 hours as needed. She has not treated with Motrin this morning because she "wanted the doctor to see her temperature." The patient symptoms started one day ago on 9/20. She stated that the patient's older sister, that is 7 years old was treated for Strep Throat one week ago. She reported that she has not looked at her throat to see if it was red. She stated that the child has not eaten her normal amount of food but has been drinking water out of her cup. She stated that she just doesn't look like she feels good and with her sister having Strep last week she wanted to make sure she brought her in to be seen. Mother reports that the child nodded her head yes when the mother asked if her throat was hurting. The mother reports irritability that started yesterday on and off throughout the day. The mother denies refusal to drink fluids, headache from what she can gather, stomachache, vomiting, and a rash. The mother denies noticing any swollen glands in the neck. She denies coughing, nasal congestion, and nasal discharge. CENTOR SCORE-4.

III. **Past Medical History:**

1. Childhood illnesses & developmental milestones
    a. Otitis media – (05/20; 09/22). Patient was prescribed Cefdinir. She completed the full course of antibiotics and the illness resolved without complications.
    b. Patient denies any previous infections with measles, mumps, rubella, whooping cough, chicken pox, rheumatic fever, scarlet fever, polio, or other childhood illnesses.

c. Milestones: Mother states she has met all physical and cognitive milestones. The patient can kick a ball, open doors, feeds herself, knows her full name and age, can count to three, names her colors, names animals, shares toys, takes turns, undresses herself, and pedals on a tricycle. She is also fully potty trained but still wears pull-ups at night. The mother states that she has occasional accidents during the night. During the exam, the patient was able to answer questions and communicate using 1- 2-word sentences.

2. Chronic Illnesses
    a. None.
3. Prior Illnesses and Injuries (accidents and hospitalizations)
    a. Prior illnesses listed above.
    b. Only hospitalization was birth. The patient was born at 39-weeks' gestation via vaginal delivery at Andalusia Regional Hospital. Mother reports no problems during pregnancy. She also states that the birth was uncomplicated and both herself and the patient were discharged after a 3-day hospital stay with no residual problems.
4. Past Surgical History
    a. None.

IV. Current Health Status:

1. Health Status (including potential current stress)
    a. Patient's mother believes she is in great health.
2. Allergies
    a. No known medication allergies.
    b. No known food or seasonal allergies.
3. Medications: this includes over the counter and complimentary medications/ treatments
    a. Tylenol (acetaminophen) PO – 5mL every 4 hours PRN for pain or fever over 100. Last dose was last night around 11:00 P.M.
    b. Olly toddler multivitamin gummies plus probiotic – 1 gummy each day for vitamin supplementation. Her last multivitamin was taken 2 days ago with breakfast. Has refused vitamin since she became sick.
4. Tobacco Use
    a. Denies exposure to second-hand smoke.
5. Alcohol Use
    a. Denies exposure to alcohol or any alcohol in the home.
6. Illegal/Recreational Drug Use
    a. Denies exposure to recreational drugs. Prescription medications are in a locked cabinet in the mother's bathroom.
7. Environmental hazards
    a. She wears sunscreen and a hat when outdoors. When swimming, she wears a long-sleeve swimsuit.
    b. She does not go to daycare and stay's home with grandmother while parents are at work.
    c. She has been taking swimming lessons this summer and was successful in learning to swim. She states that next year she is returning to lessons for more practice. Mother states that she still wears her lifejacket when near any water and only swims without it if the mother is in the pool and supervising.
    d. Mother reports keeping all cleaning supplies, chemicals, and poisons in a locked cabinet.
8. Safety measures

   a. Patient is in a forward-facing car seat in the back seat.
   b. She wears a helmet when riding the golfcart with her grandmother and while on her scooter.
   c. The home has functioning smoke and carbon monoxide detectors.
   d. All firearms and medications are out of reach in a locked cabinet.
   e. Mother states that all furniture is secured to the wall to prevent tipping over.
   f. All electrical outlets have safety covers.
9. Exercise & leisure
   a. The patient likes to play outside with her older sister. She enjoys swinging and playing on her outside playset. She also enjoys playing with her toys and dolls in her playroom. She rarely watches TV or a tablet but occasionally watches her tablet while riding in the car. The child is supervised on the tablet and only watches age-appropriate educational videos. (Mom brought out her phone to let the child watch during the subjective portion of the exam). The mother stated that when the child is well, she is active most of the day.
10. Sleep
   a. She sleeps from 8pm-6:30am without the use of sleep medications. She occasionally awakes at night to use the bathroom, but normally sleeps through the night. She sleeps in a toddler bed in a room she shares with her older sister. They have a nighttime routine that includes bath time, brushing teeth, reading a book, and bedtime. She normally takes a nap during the day while at her grandmothers for 1.5-2 hours. Mother states she may nap more often if on long car rides or going out of town on the weekends. Since becoming sick, she did wake up 3 times last night but was easily consoled back to sleep.
11. Diet
   a. Mother states that the patient will eat "almost anything when feeling well." Yesterday she half a banana (which she usually eats the entire banana) for breakfast. One sip of GoGo squeeze yogurt which she normally enjoys for a morning snack. Lunch consisted of a peanut butter and jelly sandwich with apple slices, which she only ate a couple bites of the sandwich and one apple slice. She denied interest in an afternoon snack. For dinner, she had chicken fingers and macaroni and cheese. She had one bite of macaroni and did not touch the chicken fingers on her plate. She drinks mostly water with occasional water flavor packets added. <u>She drank approximately 3 cups of water yesterday which is her normal.</u> She drinks a 12oz cup of milk in the morning and at night before their bedtime routine (since becoming sick, she has refused milk). She also occasionally drinks 1-2 cups of apple juice or grape juice.
12. Immunizations
   a. Hep B: series complete (administered in office at birth, 2mo., and 9mo.)
   b. Rotavirus: series complete (administered in office at 2mo. and 4mo.)
   c. DTaP: Has received 4 doses. (administered in office at 2mo., 4mo., 6mo., and 18mo.) She will receive final dose at her 4-year-old well-child appointment.
   d. HiB: series complete (administered in office at 2mo. 4mo., and 12mo.)
   e. PCV13: series complete (administered in office at 2mo., 4mo., 6mo., and 12mo.)
   f. IPV: She has received 3 doses (administered in office at 2mo., 4mo., and 9mo.) Will receive the final dose at her 4-year-old well-child appointment.

g. MMR: Has received first dose at 12mo. Will receive final dose at 4-year-old well-child appointment.
h. VAR: Has received first dose at 12mo. Will receive final dose at 4-year-old well-child appointment.
i. Hep A: series complete (administered in office at 12mo. and 18mo.)
j. She receives the flu shot annually beginning at 9 months old. Has not received flu vaccine this year. Is planning to come back once pt is well.
k. Mother declined COVID vaccination.

13. Preventive Screening tests
    a. Dental: started seeing dentist at 1-year-old. She goes every 6-months. Her next appointment is in November 2022.
    b. Vision screening: Pt started seeing an optometrist last year and sees Dr. Barton yearly. No problems with vision. Next appointment is in November 2022.
    c. BP check at 3-year-old wellness on 02/05/22 and was WNL.
    d. Hearing screening was conducted on 02/05/22 at 3-year-old wellness and was WNL. Mother reports no problems with hearing that she is aware of.

V. Family History- should go back at least 3 generations (patient, parents, and grandparents):

a. Maternal grandmother, alive at age 52. Hx of HTN.
b. Maternal grandfather, alive at age 53. Hx of DM.
c. Paternal grandmother, alive at age 48. Hx of HTN.
d. Paternal grandfather, alive at age 50. No known medical history.
e. Mother, alive at age 26. Hx of anxiety.
f. Father, alive at age 28. No medical conditions.
g. Sister, 7 years old. No medical history.
h. Patient, 3 years old. No medical history.

- Patient health risk assessment and analysis: Patient is at risk for HTN due to strong family history of HTN in maternal grandmother and paternal grandmother. She is also at risk for DM due to her maternal grandfathers history of DM. She is at risk of anxiety due to mother's history of anxiety. The patient can avoid these chronic health problems by following the health promotion plan, staying up-to-date on well-child check-ups, maintaining a healthy diet, and getting plenty of exercise.

VI. Social History:

1. Education – Patient is kept at home with grandmother while mother is at work. She engages with the child with educational play. Mother holds an associate's degree in science. Father holds a high school diploma.
2. Occupation – Patient's mother is an office secretary at Andalusia High School. Patient's father works for himself cutting grass with his father, whom he owns the company with.
3. Marital status – Patient's parents are married and have lived together for 8 years.
4. Children/dependents – Patient has one sister who is 7 years old.
5. Type of housing & who the patient lives with – A 3-bedroom, 2-bathroom brick home that they are currently renting. The patient lives full-time with her mother, father, and older sister. Both parents are highly active in the child's life.
6. Financial resources/insurance – Both parents work full-time. She has Medicaid insurance. Denies problems paying for housing, medication, or food.

7. Religion/beliefs – Patient's mother reports being a Christian but is not currently involved in church or other religious groups/activities. She reports that the patient went to vacation bible school this summer at a church her grandparents attend weekly. She has no religious preferences related to healthcare.
8. Social involvement –She enjoys going to her grandparents' house while her mother is at work. Grandmother has a pool that they go swimming in during the summer. She enjoys playing with her older sister and cousins. Mother states she has expressed an interest in taking dance classes and plans to sign her up at Andalusia Dance and Tumbling.
9. Travel – Mother denies any recent travel.
10. Erickson's Stage of Development – She is in the Autonomy vs. Shame/Doubt stage. I believe she is in this stage because she is learning how her personal choices affect her surroundings. She is potty trained and making healthy food choices. She also has a choice on activities she wants to participate in (dance). She also shows a huge interest in picking out her cloths each morning. This shows that she is progressing through the autonomy stage appropriately.

VII. **Review of Systems:** (Include all systems)

1. **General/Constitutional:** Denies weight change, weakness, night sweats, anorexia, and malaise. Mother reports fever yesterday and today with the highest reading of 103 last night. Mother reports fatigue and decreased appetite.
2. **Integumentary:** Denies skin color changes, bruising, sores, rashes, itching, or infections. Denies a rash.
3. **Head, eyes, ears, nose, and throat/mouth(HEENT):** Denies headache, head injury, or facial swelling. Denies vision changes, squinting, excessive blinking, eye or eyelid redness, excessive tearing, use of glasses, history of glaucoma or cataracts. Denies hearing loss, pulling at ears, drainage from ears, ear pain, or recent ear infections. Denies runny nose, congestion, sneezing, nasal drainage, allergies, nasal flaring, nose pain, nose bleeds, or loss of smell. Reports sore throat and nods head yes when NP asks if her throat hurts. Denies drooling, mouth soreness, dryness, ulcers, sore tongue, bleeding gums, cavities, or gum disease.
4. **Neck:** Denies lumps, swollen lymph nodes or glands, pain, or decreased mobility/ROM.
5. **Cardiovascular:** Denies chest pain, shortness of breath on exertion or at rest, difficulty breathing while lying flat, edema, fainting, or lethargy.
6. **Thorax:** Denies breast lumps, pain, nipple discharge, or gynecomastia.
7. **Respiratory:** Denies coughing, abnormal breathing pattern, skin color changes, abdominal breathing, wheezing, gasping, a history of asthma, and exposure to TB.
8. **Gastrointestinal:** Denies nausea, vomiting, diarrhea, abdominal pain, excessive belching or flatulence. Reports daily BMs – last BM was this morning and stool was formed, soft, and brown. No blood or mucus noted in stool. Mother reports a decrease in appetite from the child's normal eating habits and thinks it is because the child's throat hurts. Denies a decrease in fluid consumption. Denies trouble swallowing.
9. **Genitourinary:** Denies urinary frequency, excessive bed wetting, blood in urine, and pain on urination.
10. **Musculoskeletal:** Denies limited range of motion and weakness.
11. **Neurologic:** Denies lethargy, fainting, seizures, memory changes, headaches, or dizziness.

12. **Psychiatric:** Denies nightmares or phobias. Reports irritability during the daytime and at night since the patient developed a fever. Reports the patient woken from sleep 3 times last night and was easily consoled back to sleep. Patient is slightly fearful of NP during the exam.
13. **Endocrine:** Denies heat/cold intolerance, excessive sweating/flushing, excessive thirst/hunger, and excessive urination.
14. **Hematologic/Lymphatic:** Denies anemia, bruising, bleeding, and swollen lymph nodes.
15. **Allergic/Immunologic:** Denies seasonal allergies, runny nose, itchy eyes, congestion, hives, immunocompromised states, or other frequent infection. Denies exposure to COVID-19 and influenza virus. Reports exposure to strep throat infection.

VIII. **Physical Examination**: (Include all systems)

1. **General appearance**: Patient is a 3-year-old female who appears her stated age. She is alert and oriented. She appears tired. She appears to be normal height/weight and stated age. No evidence of abuse or trauma. She appears well-nourished and well-hydrated. She a bit curious of the NP and student but is interacting appropriately.
2. **Vital signs**:
   Height: 36.5in.
   Weight: 33lbs
   BMI: 17% normal
   Blood Pressure: 90/65 (right arm; sitting)
   Pulse: 110bpm (slightly elevated but within normal limits, probably due to fever).
   Respirations: 22
   O^2 Saturation: 100%
   Temperature: 102.3 (right tympanic)
3. **Skin**: Pink, dry, and warm. No diaphoresis, cyanosis, or pallor noted. No other lesions, rashes, bruising, or discolorations noted.
4. **HEENT**:
   HEAD: Skull is normocephalic without deformities. Scalp is clear with black hair that is evenly distributed. Cranial Nerve 7 (facial): all facial features are symmetric at rest and in motion. Cranial Nerve 5 (trigeminal): facial muscles do not tremor when jaw is clinched, and no clicking is noted over the TMJ.
   EYES: No ptosis or lid swelling noted. Sclerae white. Conjunctiva is pink with no hemorrhages noted. Cornea is clear and moist. Iris is flat and brown. Cranial Nerve 2 (Optic): pupils are PERRLA; fundoscopic exam: the fundal background is a deep red color without exudates or lesions; optic disc and macula is well defined, no evidence of retinal vascular hemorrhages or narrowing of vessels. Cranial Nerve 3, 4, 6 (oculomotor, trochlear, and abducens): + EOM in 6 directions. SPOT vision screening WNL. Snellen chart test not indicated for this patient due to age. Pt sees an optometrist yearly and vision WNL.
   EARS: No tenderness noted with movement of tragus or pinna. External auditory canal is clear, no redness, edema, and minimal cerumen noted. Bilateral tympanic membranes are pearly gray, boney landmarks, and cone of light noted. Cranial Nerve 8 (auditory): whisper test revealed to be intact.
   NOSE: Nasal septum is midline. Turbinates and nasal mucosa are pink and moist. No tenderness over maxillary and frontal sinuses on palpation and percussion. Sinuses transilluminate. No nasal flaring noted. Cranial Nerve 1

(olfactory): Patient smelled an alcohol pad with eyes closed showing that it is intact.

THROAT: Lips are symmetric, pink, with no cracking or lesions. Oral mucosa is moist, pink, and intact. Inflamed uvula, pharynx, and tonsils. Pharynx erythematous with patchy white exudates. Tongue midline and pink. Teeth are white with no cavities or abnormalities noted. Cranial Nerve 12 (hypoglossal): tongue is pink, moist, midline, and moves in all directions. Cranial Nerves 9 and 10 (glossopharyngeal and vagus): posterior pharynx and tonsils are erythematous with exudates. Uvula is midline and rises when she says "ahh" and gag reflex is intact.

5. **Neck (including nodes):**

    NECK: Mobile without crepitus or decreased ROM. Thyroid is smooth, non-tender, with no nodules. Trachea is midline. No stridor noted on auscultation. Carotid arteries have symmetric upstroke without bruits auscultated. No jugular venous distention noted. Cranial Nerve 11 (Spinal accessory): patient is able to shrug her shoulders against resistance.

    NODES: Pre-auricular, post-auricular, tonsillar, occipital, anterior cervical, posterior cervical, submandibular, submental, axillary, epitrochlear, and inguinal lymph nodes are all non-tender and non-palpable.

6. **Cardiovascular & Peripheral Pulses:**

    Inspection: No visible pulsations or lifts noted over the precordium. PMI not visible.

    Palpation: No lifts, heaves, or thrills noted over the aortic, pulmonic, erb's point, tricuspid, or mitral areas. PMI noted at midclavicular line, 5th intercostal space- it is dime sized with a single, regularly sustained impulse.

    Auscultation: Rate and rhythm are regular. S1 and S2 heard in the aortic, pulmonic, erb's point, tricuspid, and mitral areas. No murmurs, gallops, rubs, or clicked noted.

    Pulses: Carotids, brachial, radial, femoral, popliteal, dorsalis pedis, posterior tibial are all +2 with a regular rate and rhythm.

7. **Respiratory and Thorax/Breast:**

    Breast exam: No masses or tenderness.

    Inspection: Symmetric chest wall expansion. No grunting, tachypnea, respiratory distress, accessory muscle use, retractions, or labored breathing noted. No audible stridor noted.

    Palpation: No tactile fremitus noted. No crepitus or subcutaneous emphysema noted.

    Percussion: Resonance throughout all lung fields.

    Auscultation: All lung fields are clear and equal bilaterally without crackles, wheezes, rhonchi, or rubs.

8. **Gastrointestinal (with rectal if needed):**

    Inspection: flat, symmetric, skin color consistent with surrounding areas. No bruising, scars, or abnormal venous patterns noted.

    Auscultation: bowel sounds are present and normoactive x 4 quadrants. No bruits auscultated over aorta, iliac, or femoral arteries.

    Percussion: Not indicated.

    Palpation: No tenderness to light or deep palpation noted in abdomen.

    Rectal exam: Not clinically indicated.

9. **Genitourinary:** Not indicated at this time. Female genitalia exam not clinically indicated.

10. **Musculoskeletal:** Patient is moving well and ambulates without assistance. She can climb onto the exam table independently by using the step stool. No abnormal curvature or posture abnormalities noted. Upper and lower extremities are symmetric with no edema, cyanosis, clubbing, or tremors. Patient is able to hop and balance on one foot bilaterally.
11. **Neurologic**: Awake, alert, and oriented to person, place, and time. Cranial Nerves I-XII are intact (assessed and documented in HEENT sections). Appropriate behavior and attention. Language is comprehensible. Memory appears appropriate based off her engagement during the examination. Regular gait and appropriate balance noted. No involuntary movements or tremors noted. Her limb tone is normal with no contractures. Muscle strength is +5 in all extremities. She can put finger-to-nose with her eyes closed. Romberg test was negative. +2 DTR in biceps, triceps, brachioradialis, patellar, Achilles, and plantar. Babinski is negative.
12. **Psychiatric**: Appropriate mood and affect. Age-appropriate attention noted. Appearance is appropriate for age.
13. **Hematologic/Immunologic:** No visible bleeding, bruising, or petechiae noted.

IX. **Diagnostic Testing**: (with rationale and results if available)

- Rapid Strep Antigen Test – To quickly ascertain whether the patient has streptococcal bacteria in her throat. Results: Positive.
- CBC- Was not ordered but could be performed to detect a WBC count increase or a viral shift if viral infection was suspected. Not performed due to positive Strep test.

X. **Differential Diagnosis with ICD-10 codes: Office visit level 3- established patient (99213)** (with definition and rationales supporting and refuting for each)

- **Acute Streptococcal Pharyngitis – J02.0**
  - Definition: Acute inflammation of the pharynx/tonsils due to streptococcal bacterial infection.
  - Supporting data: Physical exam findings of posterior pharynx exudate, temp of 102.3, absence of cough – CENTOR score of 4. Pt. Nodded her head when asked if her throat was hurting. Exposure to strep by older sister. Decrease in appetite, mother believes it is because the child's throat is hurting. Positive rapid strep test.
  - Refuting data – Mother denies headache, stomachache, nausea, vomiting, and a rash from what she can gather.

- **Acute Viral Pharyngitis– JK02.9**
  - Definition: Acute inflammation of the pharynx due to a viral infection.
  - Supporting: Physical exam findings of pharynx erythema and exudate. Temp of 102.3. Inflamed uvula, pharynx, and tonsils. Nodded her head when asked if her throat was hurting. Exposure to strep by older sister. Decrease in appetite, mother believes it is because the child's throat is hurting.
  - Refuting: Positive rapid strep test. Denies nasal congestion, runny nose, and sneezing.

- **Acute Upper Respiratory Infection – J06.9**
  - Definition: An infection (usually viral) of the upper respiratory tract.

- Supporting: Physical exam findings of pharynx erythema and exudate. Pt complaint of a sore throat. Temp of 102.3.
- Refuting: Positive strep test proving a bacterial source of infection. Denies sneezing, congestion, and a cough. Denies headache or sinus pain.

- **Acute Tonsillitis – J03.90**
  - Definition: Acute inflammation of the tonsils due to a viral infection.
  - Supporting: Physical exam findings of posterior pharynx exudate, temp of 102.3, and absence of cough. Pt. Nodded her head when asked if her throat was hurting. Inflamed tonsils on PE. Reports irritability.
  - Refuting: Positive strep test proving known bacterial source. Non-tender and non-palpable lymph nodes. Decrease in appetite, mother believes it is because the child's throat is hurting. Denies swallowing difficulty. Denies weakness. Denies ear pain. Denies congestion or runny nose.

XI. **Definitive Diagnosis with ICD-10 code**:(should be included in differential diagnosis list)

- **Acute Streptococcal Pharyngitis – J02.0**
  - Definition: Acute inflammation of the pharynx/tonsils due to streptococcal bacterial infection.
  - Supporting data: Physical exam findings of posterior pharynx exudate, temp of 102.3, absence of cough – CENTOR score of 4. Pt. Nodded her head when asked if her throat was hurting. Exposure to strep by older sister. Decrease in appetite, mother believes it is because the child's throat is hurting. Positive rapid strep test.
  - Refuting data – Mother denies headache, stomachache, nausea, vomiting, and a rash from what she can gather.

XII. **Chronic Health Problems with ICD code:**

- **None**

XIII. **Plan:**

- **Acute Diagnosis: Acute Streptococcal Infection- J02.0**
  - Treatment: 7 ml Amoxicillin liquid twice daily for 10 days. Continue Tylenol 5 ml every 4 hours PRN for pain/fever. You can also give children's Motrin and alternate between Tylenol and Motrin. Continue daily Olly toddler multivitamin gummy. Continue drinking 6-8 cups of water per day. You may also give Pedialyte or popsicles.
    - Medication Profile:
    - Generic: Amoxicillin
    - Brand: Moxatag
    - MOA: Inhibit penicillin binding proteins, leading to upregulation of autolytic enzymes and inhabitation of cell wall synthesis.
    - Drug Class: Penicillin antibiotic
    - Indication: Treat certain infections caused by bacteria such as pneumonia, bronchitis, and infections of the ears, nose, throat, urinary tract, and skin.

- Dosage: 25 mg/kg/day PO divided q12h; suspension- 125 mg per 5 ml. Patient's mother administers 7mL (187 mg) every 12 hours for 10 days.
- Cost for 500 mg/ 21 capsules: Walmart – $6.57; Target – $8.99; CVS Pharmacy – $8.99. (https://www.goodrx.com/amoxicillin).

- Education: Strep throat is caused by a bacteria called streptococcus pyogenes also called group A streptococcus. If untreated, it can lead to other complications such as kidney inflammation or rheumatic fever. Symptoms may include throat pain, painful swallowing, red and swollen tonsils with white patches, red spots on the area at the back of the roof of the mouth, swollen or tender lymph nodes in the neck, fever, headache, rash, nausea/vomiting, and body aches. It is possible that your child has these symptoms but does not have strep throat. You should have your child evaluated by a pediatrician in case strep throat is the source of infection needs antibiotic treatment. Risk factors for strep may include a young age and the time of the year. Diagnosis can be suspected and even made based on physical exam findings or performing a rapid antigen test by swabbing the throat. If fever is present, you can treat with OTC Tylenol and Motrin as directed on the bottle. Your physician is likely to prescribe Amoxicillin which is first-line treatment. If taken within 48 hours of the onset of the illness, antibiotics reduce the duration and severity of symptoms, as well as the risk of complications and the likelihood that infection will spread to others. With treatment, you or your child should start feeling better in a day or two. Call your doctor if there's no improvement after taking antibiotics for 48 hours. Children taking an antibiotic who feel well and don't have a fever often can return to school or childcare when they're no longer contagious- usually 24 hours after beginning treatment. But be sure to finish all the medicine. Amoxicillin is in a class of medications called penicillin-like antibiotics. It works by stopping the growth of bacteria. Take 7 ml twice daily for ten days as directed on the prescription. Shake the suspension well before each use to mix the medication evenly. The suspension may be placed directly on the child's tongue or added to formula, milk, fruit juice, water, ginger ale, or another cold liquid and taken immediately. Side effects may include nausea, vomiting, diarrhea, changes in taste, and headache. Contact your physician right away if your child develops a rash, skin blistering or peeling, hives, wheezing, difficulty swallowing or breathing, and swelling of the face, throat, tongue, lips, and eyes. To prevent strep infection, wash your hands regularly with soap and water for at least 20 seconds. Teach your children how to wash their hands properly using soap and water or to use an alcohol-based hand sanitizer. Cover your mouth with an elbow or tissue when they cough or sneeze. Do not share personal items such as drinking utensils or drinking glasses. Wash dishes in hot, soapy water or in a dishwasher. Get plenty of rest to help your body fight the infection. Continue to encourage the child to drink plenty of fluids including water, juice, Pedialyte, and popsicles. Eat soothing foods such as broths, soups, applesauce, cooked cereal, mashed potatoes, soft fruits, yogurt, and soft-cooked eggs. You can puree foods in a blender to make them easier to swallow. Cold foods, such as sherbet, frozen yogurt or frozen fruit pops also may be soothing. Avoid spicy foods or acidic foods such as orange juice. You can use a humidifier to add moisture to the air to ease discomfort. Choose a cool-mist humidifier and clean it daily because bacteria and molds

can flourish in some humidifiers. Saline nasal sprays also help keep mucous membranes moist. Stay away from cigarette smoke and cleaning products. The child needs to change her toothbrush not tomorrow but the next day to prevent reinfection. Remember that strep throat is infectious and she should stay away from other children until she is fever free for at least 24 hours.

  - Follow-up: With pediatrician in 3-4 days if no improvement after starting antibiotics.
  - Referral: None.

- **Health Promotion**
  - Current recommended screenings:
    - Continue dental exams every 6 months.
    - Continue well-child check-ups every year.
    - Continue annual vision and hearing screenings.
  - Follow-up: Next well-child check-up is after she turns 4-years old.
  - Immunizations: At her 4-year-old checkup, she will receive the DTap, IPV, MMR, and Varicella vaccines. After these, she will be done with vaccinations until she turns 11. When patient is well, she is encouraged to return to receive her flu vaccine, no appointment is necessary.
  - Lifestyle management:
    - Remember to brush teeth twice a day. Encourage her to brush her own teeth first, then follow-up behind her to ensure adequate brushing.
    - Maintain a well-balanced diet that is high in fruits and vegetables. Limit mild to 12-24oz per day to prevent constipation. Encourage adequate water intake (6-8 cups per day). Limit the amount of sugary/caffeinated beverages she consumes to 12-24oz per day.
    - Continue to encourage physical activity. Aside from sleeping, she should not be inactive for longer than one hour at a time. Limit TV/table to no more than 30 minutes to one hour each day.
    - Wear sunscreen while outdoors. Make sure to reapply each hour when outside for extended periods of time.

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