

Auburn Montgomery Student Health Services

7461 East Dr STE 102
Montgomery AL, 36117-8092
(334) 244-3281

Date: 04/22/22

PATIENT: BARTON, SADLER **DOB:** 06/01/2012 **Gender:** MALE **MRN:** 1384 **AGE:** 9 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Fever, Vomiting

Symptoms: N/V/Fever

Duration: started this morning

Context: accompanied by mother

Other: Zofran helps

VITALS: BP: 98/59 **Pulse:** 113; **Temp:** 102.6; **Resp:** 16; **Wt:** 78 lbs.; **Pulse Oximetry:** 99%

GROWTH PERCENTILES:

Weight/Age: 70

Height/Age: N/A

Weight/Height: N/A

BMI/Age: N/A

Head Circumference/Age: N/A

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

Adhansia XR 35 mg capsule, extended release (1 tablet daily)

ProAir HFA 90 mcg/actuation aerosol inhaler (1-2 puffs every 4-6 hrs as needed)

Qvar RediHaler 40 mcg/actuation HFA breath activated aerosol (2 puffs BID)

Singulair 5 mg chewable tablet (1 tablet PO daily)

PAST MEDICAL HISTORY: asthma, ADHD

PAST SURGICAL HISTORY: Denies

SOCIAL HISTORY: Lives with parents. In school elementary school.

FAMILY HISTORY: Mother- pituitary microadenoma, migraines, GERD; Father- Asthma, HLD.

REVIEW OF SYSTEMS:

CONSTITUTIONALS: All 14 point review of systems negative except those listed in HPI.

PHYSICAL EXAMINATION:

GENERAL: GENERAL: No apparent distress noted; Well developed; Pleasant.

HEENT: Head- normocephalic; atraumatic. Eyes- sclera white, conjunctiva pink, EOMI. Ears- tympanic membranes clear. Ear canals are patent. Nose- septum- midline; Throat- erythema with tonsil enlargement without exudates.+ cervical nodes palpated;

CARDIOVASCULAR: S1 S2; Regular rate and rhythm; No systolic ejection murmurs noted;

RESPIRATORY: Breath sounds equal and unlabored. Clear to auscultation bilaterally without wheezes, rales, or rhonchi.

GASTROINTESTINAL: Abdomen is soft; Nontender; Nondistended. Bowel sounds present x 4 quadrants.

Auburn Montgomery Student Health Services

7461 East Dr STE 102
Montgomery AL, 36117-8092
(334) 244-3281

Date: 04/22/22

PATIENT: BARTON, SADLER **DOB:** 06/01/2012 **Gender:** MALE **MRN:** 1384 **AGE:** 9 Years

MUSCULOSKELETAL: Normal range of movement x 4 extremities

INTEGUMENTARY: Warm, dry, intact. No lesions or rash noted.

NEUROLOGIC: Alert and Oriented X3. CN II-XII intact. Sensation intact. Speech clear. Ambulates with steady gait.

PSYCHIATRIC: Appropriate mood and affect.

ORDERS:

STREP A (1 unit(s)): In-House Lab

INFLUENZA (1 unit(s)): In-House Lab

RESULTS:

STREP A:

Value: Negative

INFLUENZA:

Value: Positive

Comment: Flu A

ASSESSMENT:

J02.9 - ACUTE PHARYNGITIS, UNSPECIFIED (PRIMARY)

R50.9 - FEVER, UNSPECIFIED

R11.10 - VOMITING, UNSPECIFIED

J11.1 - Influenza due to unidentified influenza virus with other respiratory manifestations

PLAN:

Tamiflu to pharmacy. School excuse given to mom. Call with worsening s/s. Fluids and electrolytes recommended.
Small, comfort meals. Tylenol/Ibuprofen for HA and Fever.

Tamiflu 30 mg capsule

Refills: 0 Qty: 20 TABLET(S)

Instructions: Take 60 mg (two tablets) PO BID for 5 days.

Electronically signed by Maranda Fain, CRNP on 04/22/22 9:02 AM

M. Fain, CRNP