

**Date:** [Date of Visit]

**Patient Name:** [Patient Name]

**Date of Birth:** [Date of Birth]

**Guardian Name:** [Guardian Name]

---

## **Provider Evaluation Summary**

**Chief Complaint:** [Reason for Visit]

**Diagnosis:** [Primary Diagnosis/Impression]

**Vitals at Discharge:** [Temp, HR, RR, O2 Sat]

## **Treatment Provided**

[List medications administered or procedures performed during the visit]

## **Home Care Instructions**

- **Medications:** [Dosage and frequency for home meds]
- **Activity:** [Rest/School/Physical activity restrictions]
- **Diet:** [Hydration or food instructions]

## **Follow-Up Requirements**

Please schedule a follow-up appointment with your Primary Care Physician (PCP) within [Number] days.

## **When to Return or Seek Emergency Care**

Seek immediate medical attention or call 911 if the child experiences:

- Difficulty breathing or blue tint around lips
  - Dehydration (no wet diapers, dry mouth)
  - Inconsolable crying or extreme lethargy
  - Fever that does not respond to medication
  - [Specific Red Flag symptom related to diagnosis]
- 

**Evaluating Provider:** [Provider Name/Title]

**Facility Name:** [Clinic Name]

**Contact Number:** [Phone Number]