

montana pediatrics

***Pediatric Clinic
Manual***



HPDP Telemedicine
Program

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Introduction

Welcome to Our Dream!

Since our first day of telemedicine coverage at Fort Peck on July 13, 2020 so much has been accomplished to support our common goal: Improving the health and healthcare access for the children at Fort Peck. We are so grateful for the individual moments when we are able to support your amazing and dedicated staff in service to each individual child. We are also able to see that the time together is leading to more use of the services and trust between everyone involved.

We are honored to be part of seeing children with everything from simple ear pain, severe moments of psychological distress, concerns about return-to-play and even just being part of solving the technology challenges that we are all learning to navigate together.

COVID-19 has certainly made the work much harder, but also, we hope, has been part of demonstrating our dedication and the importance of connecting with Montana providers who can adapt and connect to resources in our state. We are grateful to be part of increasing capacity and healthcare options for HDPD and we have also been so heartened to see the responsiveness of the SBHC nurses, NPs and CNAs and the Montana Pediatrics providers in working together to overcome barriers to improving pediatric health.

Quality pediatric care with involvement of nurse, provider and specialist in a collaborative manner such as what we are able to provide with telemedicine, is rare to find in Montana ANYWHERE and we are so excited to see it being offered at Fort Peck. Without telemedicine care often can result in a several weeks wait to being assessed and scheduled for with a provider, a long drive to Billings and back, a child missing school, a guardian missing work and all of the financial impacts on the family due to transportation and travel needs.

Montana Pediatrics providers worked hard to complete this manual: "The Pediatric Clinic Manual 1st Ed., 2021". This manual provides pediatric medical best practice guidelines and decision trees to support optimal assessment, decision making on care and outcomes for any child in, any setting. The evidenced based information has been revised to meet the needs of rural communities and providers. This work serve as the template for us to add to as quality improvement projects, clinical research, provider inquiry and ongoing changes in medical information evolves. We hope you find it an essential tool for your clinics and staff.

Know that each visit we have been a part of has been an honor, a chance for all of us to learn together, and a step on our journey to a long-term, accountable, connected, respectful and sustainable solution to access to care for the children of the Fort Peck Tribes. We fully realize that we need to continue our work to be trusted, useful and accessible.

Thank you very much!

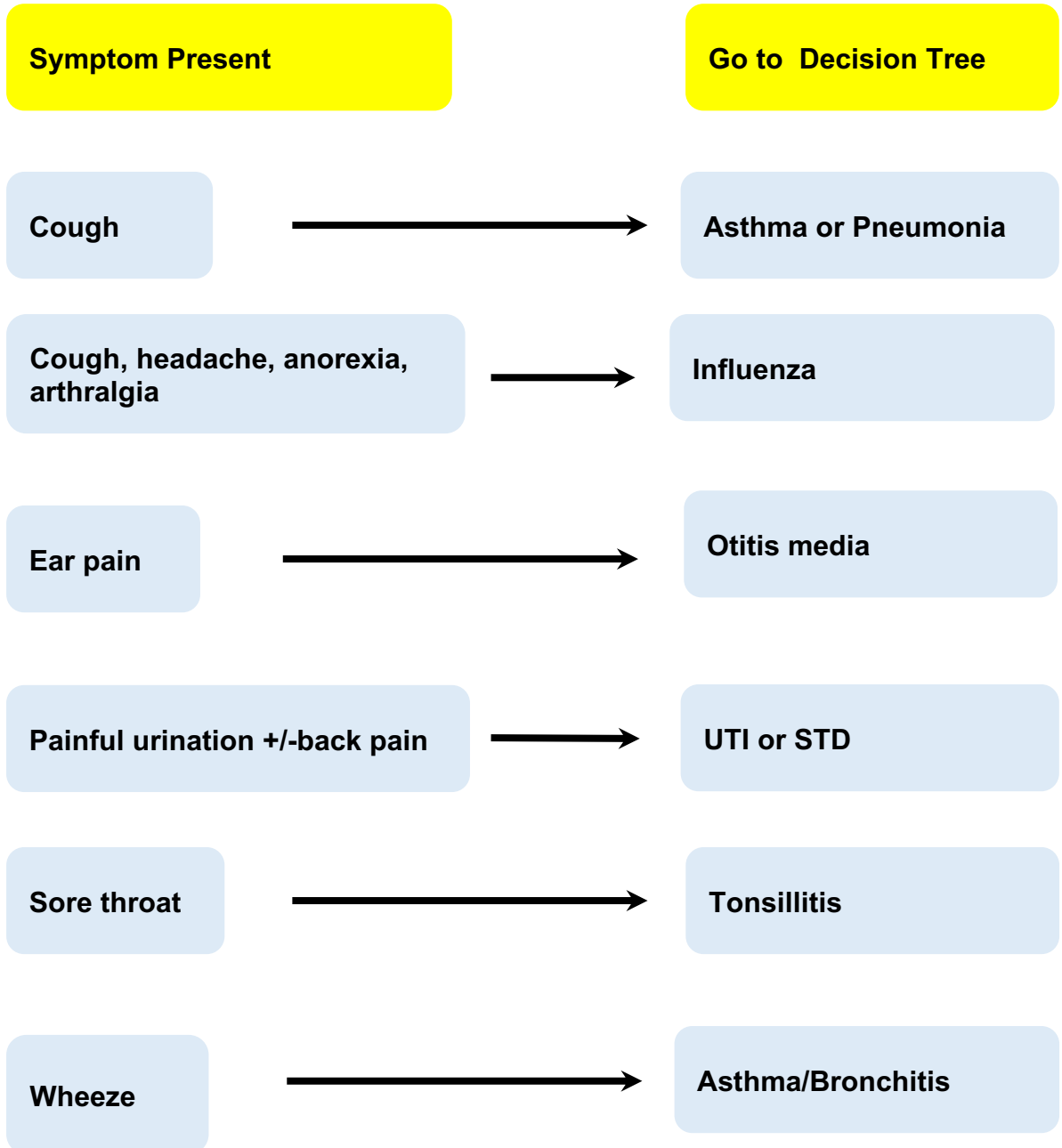
Chelsea Bodnar MD
CEO, Montana Pediatrics

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Symptom Guide



Acne

Acne is a very common condition of young adults.

Acne occurs when there is an over production of oil with an increase in bacteria, leading to clogged hair follicles. Dead skin and oil block the pores causing lesions of the skin.

MILD ACNE: Non-inflammatory lesions, which consist of open and closed comedones (blackheads and whiteheads, respectively) present; may be accompanied by a few superficial inflammatory lesions, such as papules/pustules.

MODERATE ACNE: Many inflammatory lesions present, largely superficial, but more deep-seated pustules and papules evident. There is a tendency of these lesions to scar mildly with time.

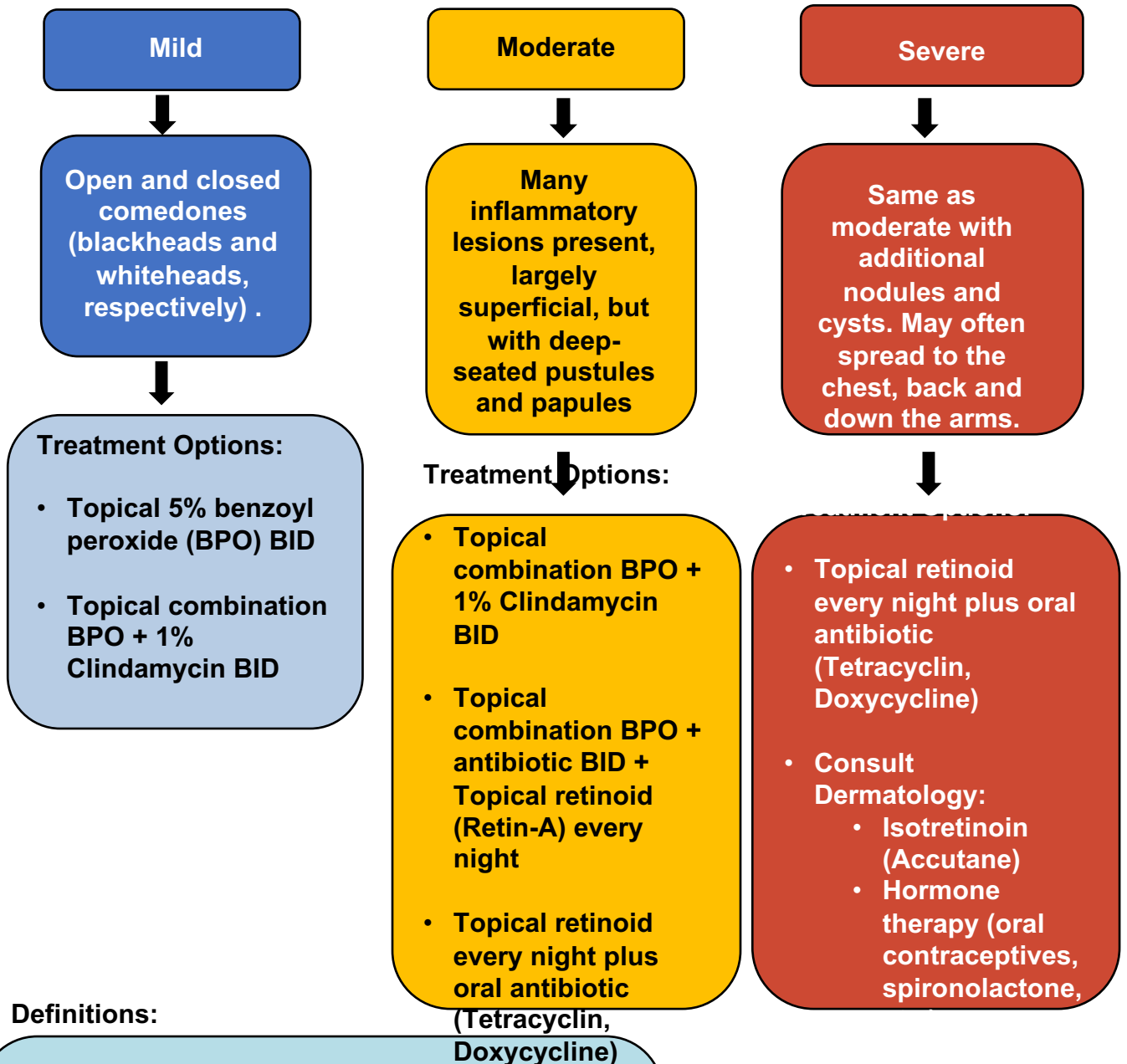
Inflammatory lesions are those that have ruptured. They appear red and sometimes have pus in them. They occur when the follicle contents from a non-inflammatory lesion get into the surrounding tissue. The body reacts by sending blood cells and chemicals to get rid of the invasion. As a result, the area becomes swollen and inflamed.

Inflammatory lesions fall into three categories: papules, pustules, and nodules. Papules are commonly referred to as "pimples." They are small, firm, reddish lesions. They are the least severe of inflammatory lesions. They generally do not contain pus. Pustules are essentially pimples that contain pus, which is a substance produced by the body to fight infection.

SEVERE ACNE: Consists of the above description with nodules and cysts. Marked scarring is evident, which may be keloidal in some cases. May often spread to the chest, back and down the arms.

Nodules are large, inflammatory lesions occurring deep in the skin. They contain a lot of pus and can lead to scarring. The nodules may progress into large cysts, which usually are associated with more inflammation and swelling.

Acne



Definitions:

- Comedone-closed = blackhead
- Comedone-open = whitehead
- Papule = pimple
- Pustule = small white or yellow spots surrounded by a swollen reddish painful area, which is an infected and inflamed hair follicle with the contained sebum
- Nodule = Solid and painful lesions deep under the skin
- Cyst = Painful, but softer lesions deep under the skin

Attention Deficit Disorder

Behavior problems in children and adolescents is thought to effect approximately 18% of all children, ADHD is thought to present in half, or 8 to 9% of pediatric population.

Any child where there is a concern for excessive impulsivity, hyperactivity, attention deficit, and school failure should be considered for evaluation.

Diagnostic criteria, per DSM-IV, need to be present in at least 2 major life settings, i.e., home, school, work, etc. In most cases, diagnostic questionnaires should be completed by parent(s) and a teacher (NICHQ Vanderbilt Assessment Scales).

Other potential causes of behavior problems must be evaluated.

Behavioral treatment should be considered first and applied, if practical.

When onset in adolescents occurs, drug abuse should be added to the differential diagnosis.

When pharmacological treatment is selected, stimulants are indicated as a first line treatment. These are based upon methylphenidate first, then dextroamphetamine as a second choice. Other agent shown to be effective in some children, include: selective norepinephrine re-uptake inhibitor (atomoxetine) and Alpha agonists (guanfacine and clonidine).

Medications are generally started at lowest possible dose and titrated upward to gain desired effect with minimal side effects.

Close follow up, every one to two weeks, as titration ensues, is essential. Stress to parents that there is no 'magic', that therapy will likely need to be changed and adjusted.

When stable, children are seen at least every three to six months to monitor for efficacy and side effects.

A standardized evaluation and monitoring tool, such as the Vanderbilt ADHD Rating Scale, should be used

Asthma

DIAGNOSIS:

Mild Asthma: No shortness of breath at rest, can talk normally with absent or mild wheezing (Green Zone on Asthma Action Plan with Peak Flow at 80-100% of normal).

Moderate Asthma: Shortness of breath at rest, speaks in phrases, can't lay down flat and wheezing is heard, rib retractions with each breath (Yellow Zone on Asthma Action Plan with Peak Flow at 50-80% of normal) .

Severe Asthma: Severe shortness of breath at rest, speaks in single words, loud wheezing and severe rib retractions with each breath (Red Zone on Asthma Action Plan with Peak Flow at <50% of normal).

Peak Flow Meter: measures the peak flow rates and tells how much air is moving out of the lungs. Used in children 6 years and older to determine the severity of an asthma attack.

TREATMENT:

Look at the child's Asthma Action Plan and treat as indicated based on the symptoms with an albuterol inhaler/nebulizer or may require immediately taking the child to the ED depending on severity or if the child is needing albuterol more than every 4 hours. May require inhaled or oral steroids or admission to the hospital if a child is not responding to home treatments with worsening respiratory distress.

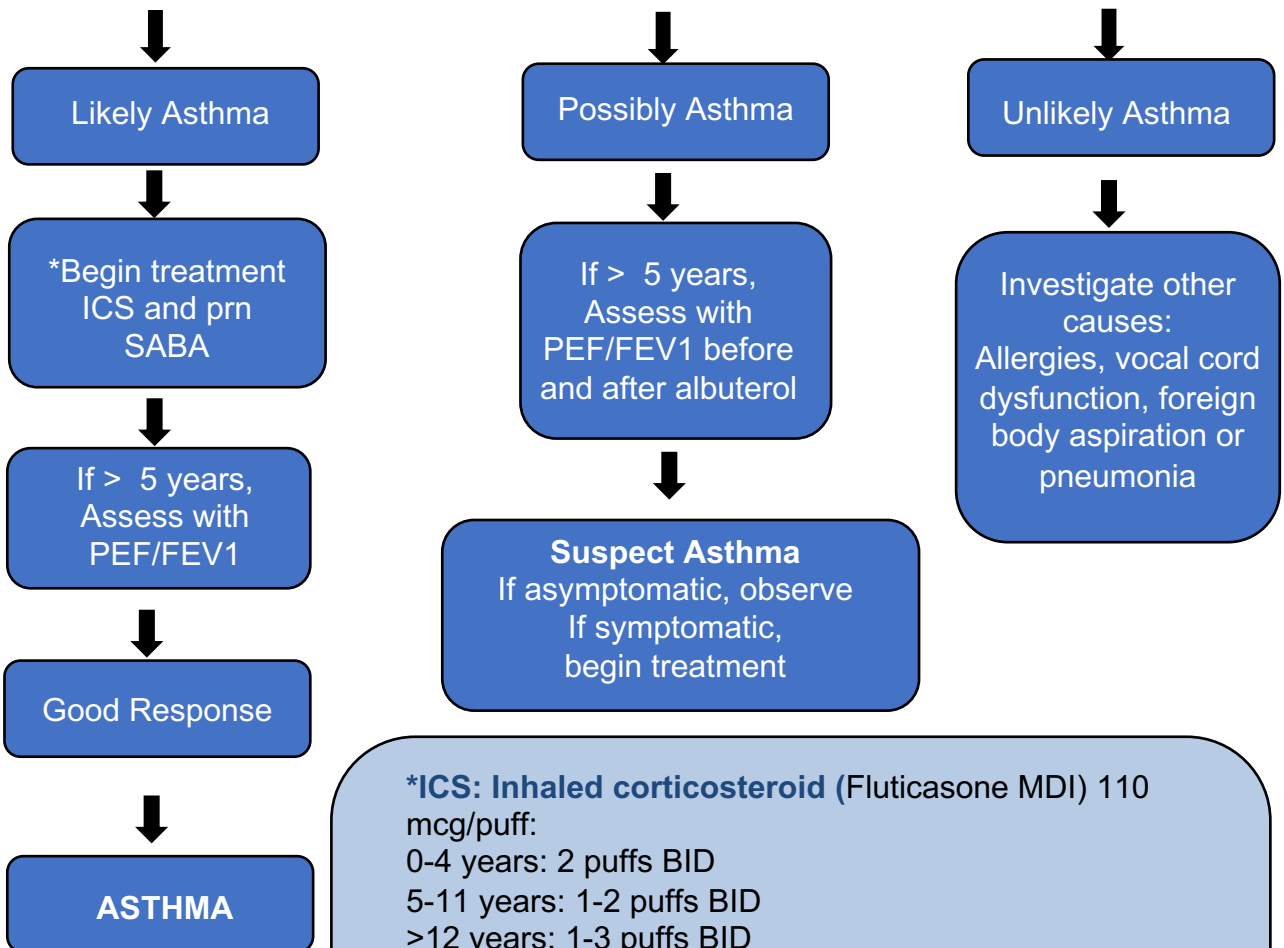
Asthma

Presentation of ANY of the following:

Wheezing, Shortness of breath, Cough, or Chest tightness

Past History Red Flags:

Recurrent similar symptoms, Atopy (allergies), Wheeze, or Variable PEF/FEV1



***ICS: Inhaled corticosteroid** (Fluticasone MDI) 110 mcg/puff:

0-4 years: 2 puffs BID

5-11 years: 1-2 puffs BID

>12 years: 1-3 puffs BID

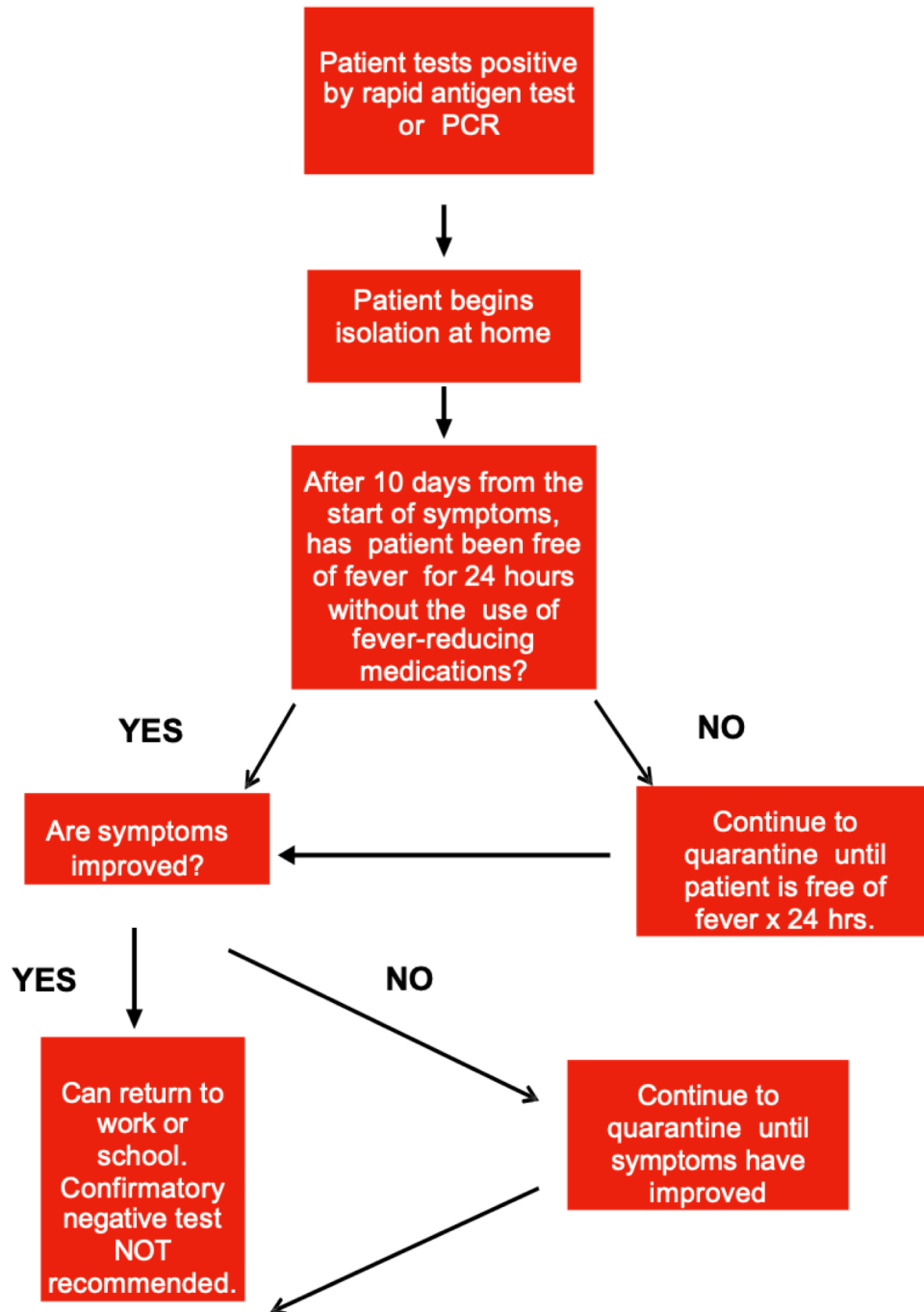
SABA: short acting beta2 agonist (Albuterol MDI)

>=4 years of age and older: 2 puffs q 4 H as needed

<4 years: Consult medical provider.

Use VHC spacer. Add mask in children less than 4 years.

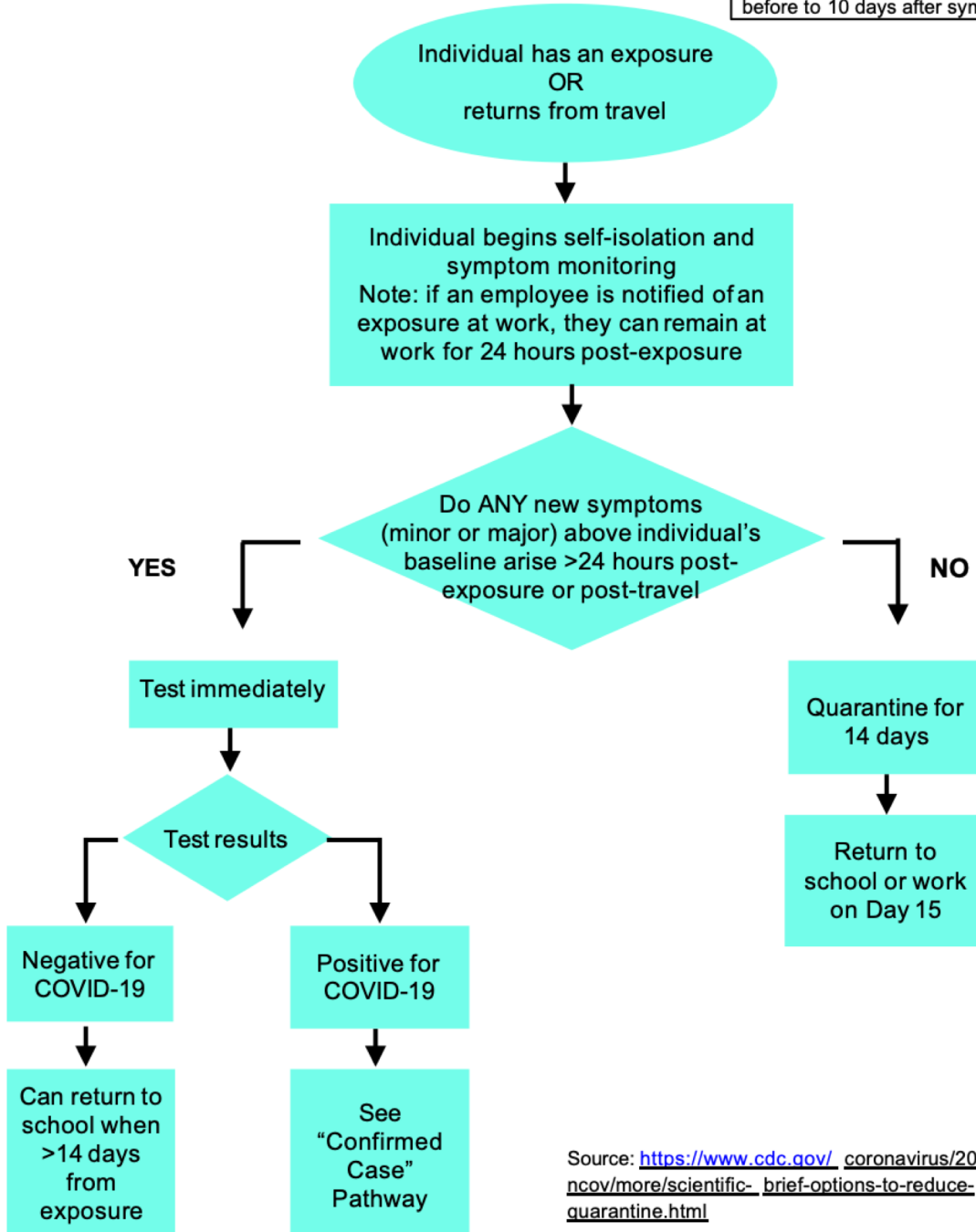
COVID-19 Confirmed Case



****Note: symptoms do need to be 100% improved for patient to return**

COVID-19 Quarantine (full)

Exposure is defined as being within 6 feet of a confirmed case for 15 minutes, from 2 days before to 10 days after symptoms began.

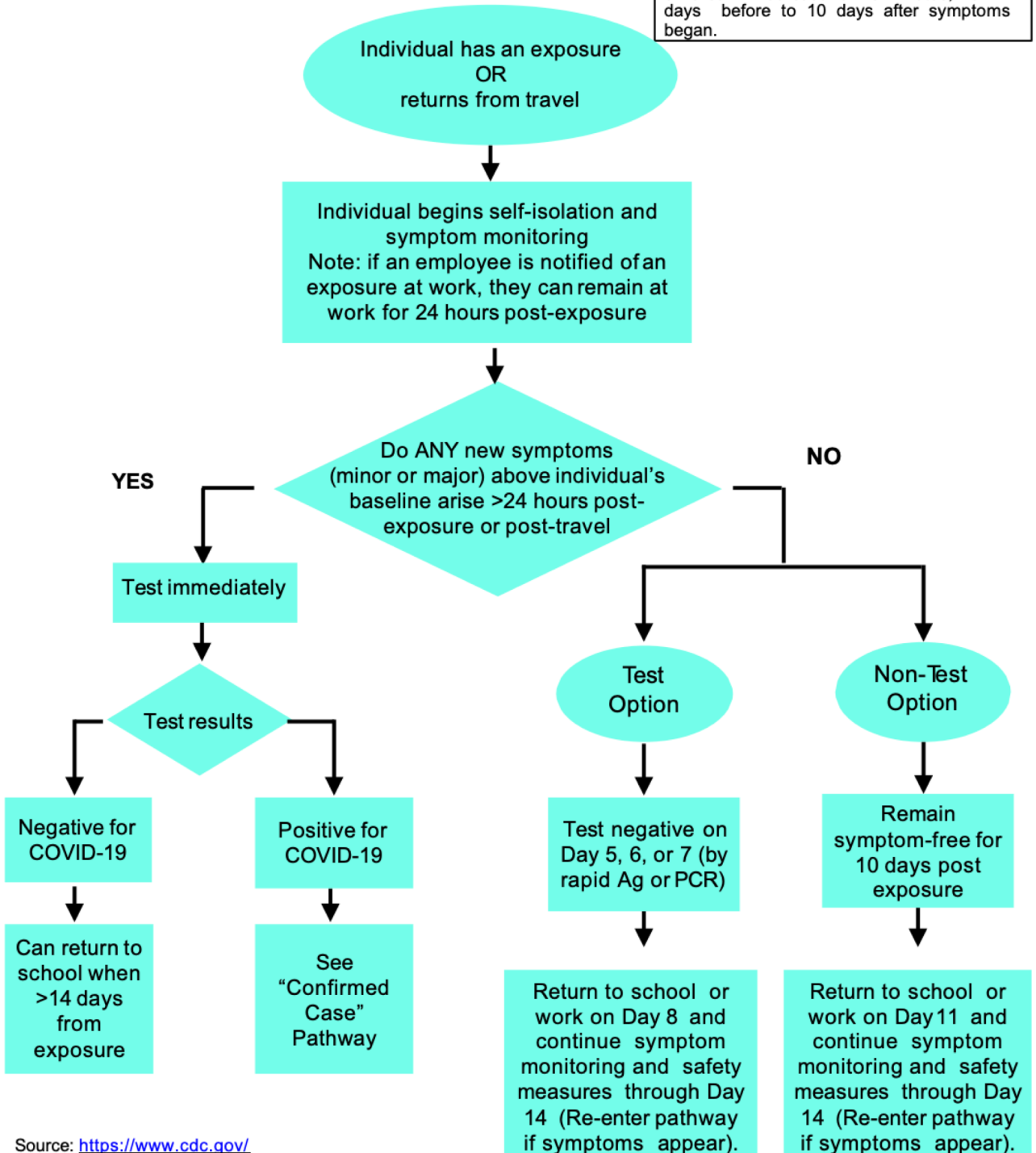


Source: <https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-options-to-reduce-quarantine.html>

Reviewed 2/24/21

COVID-19 Quarantine (reduced)

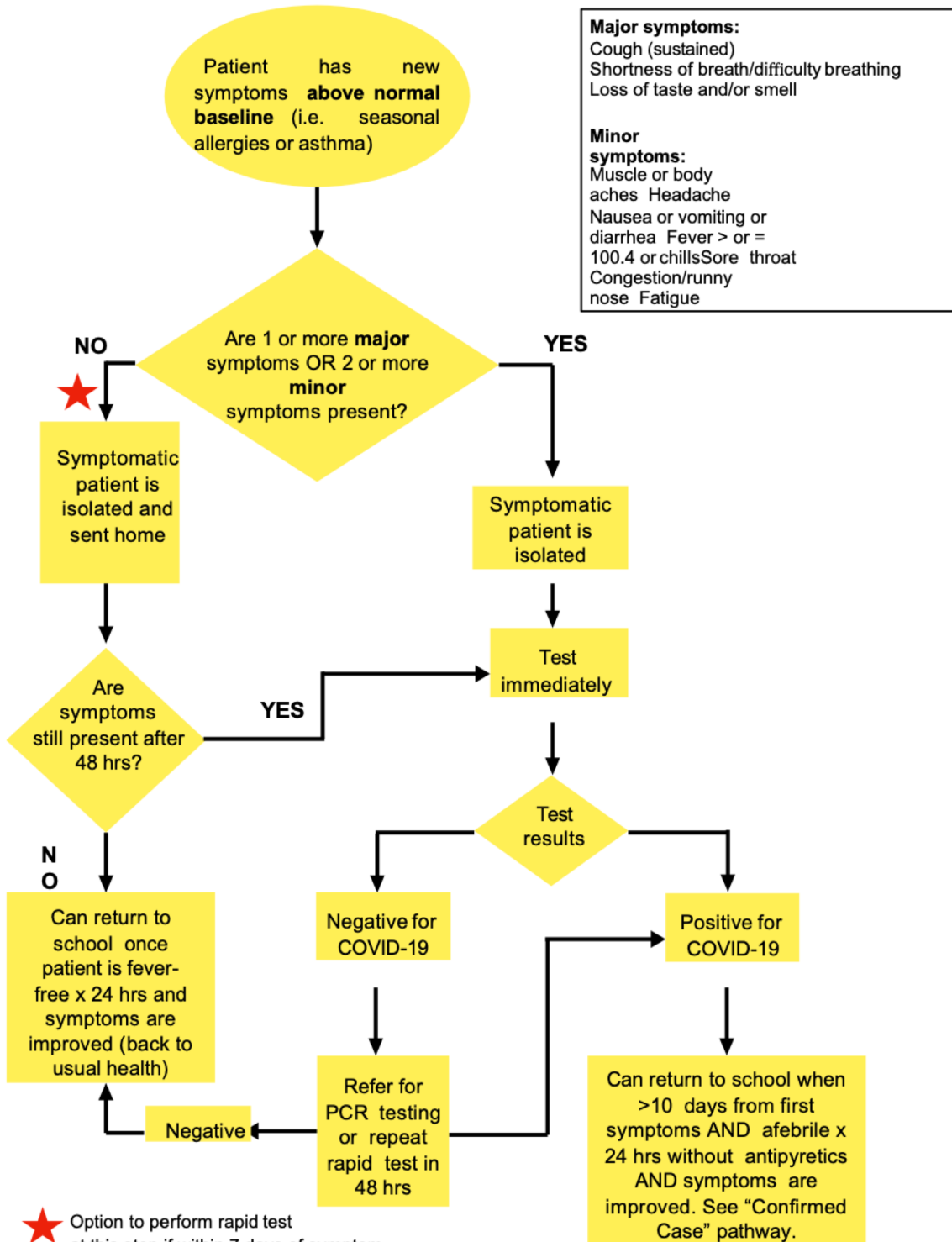
Exposure is defined as being within 6 feet of a confirmed case for 15 minutes, from 2 days before to 10 days after symptoms began.



Source: <https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-options-to-reduce-quarantine.html>

Reviewed 2/24/21

COVID-19 Symptomatic

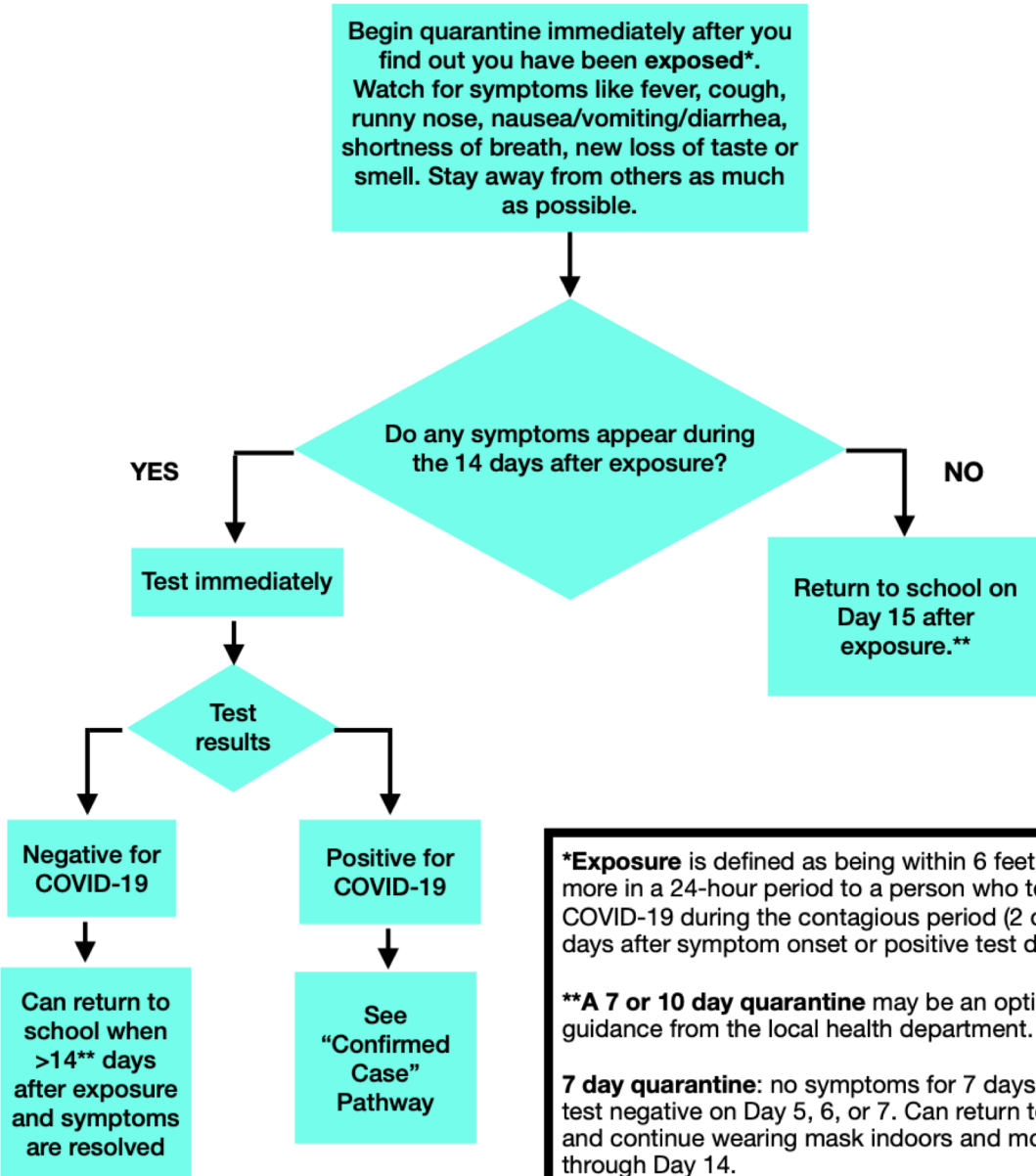


Major symptoms:
 Cough (sustained)
 Shortness of breath/difficulty breathing
 Loss of taste and/or smell

Minor symptoms:
 Muscle or body aches
 Headache
 Nausea or vomiting or diarrhea
 Fever > or = 100.4 or chills
 Sore throat
 Congestion/runny nose
 Fatigue

★ Option to perform rapid test at this step if within 7 days of symptom onset-enter pathway at "test immediately"

I've been exposed to someone with COVID-19. How long do I quarantine? I am NOT vaccinated.



***Exposure** is defined as being within 6 feet for 15 minutes or more in a 24-hour period to a person who tested positive for COVID-19 during the contagious period (2 days before and 10 days after symptom onset or positive test date)

****A 7 or 10 day quarantine** may be an option based on guidance from the local health department.

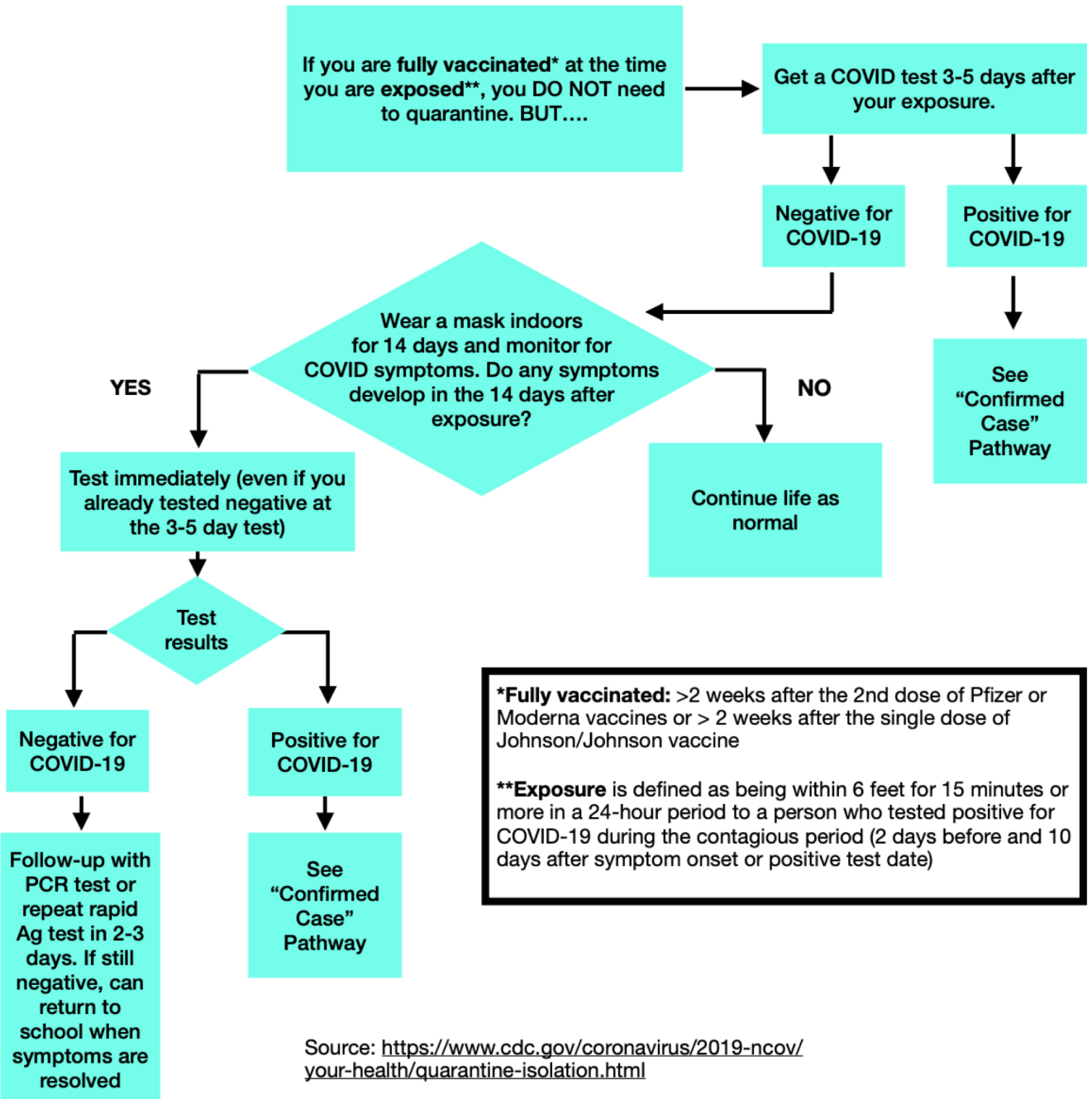
7 day quarantine: no symptoms for 7 days after exposure AND test negative on Day 5, 6, or 7. Can return to school on Day 8 and continue wearing mask indoors and monitor for symptoms through Day 14.

10 day quarantine: no symptoms for 10 days after exposure. Can return to school on Day 11 and continue wearing mask indoors and monitor for symptoms through Day 14.

Source: <https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html>

Updated 9/14/21

I've been exposed to someone with COVID-19. Do I need to quarantine? I AM vaccinated.



Source: <https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html>

Updated 9/14/21

Guidance for COVID-19+ Close Contacts in School

Glossary

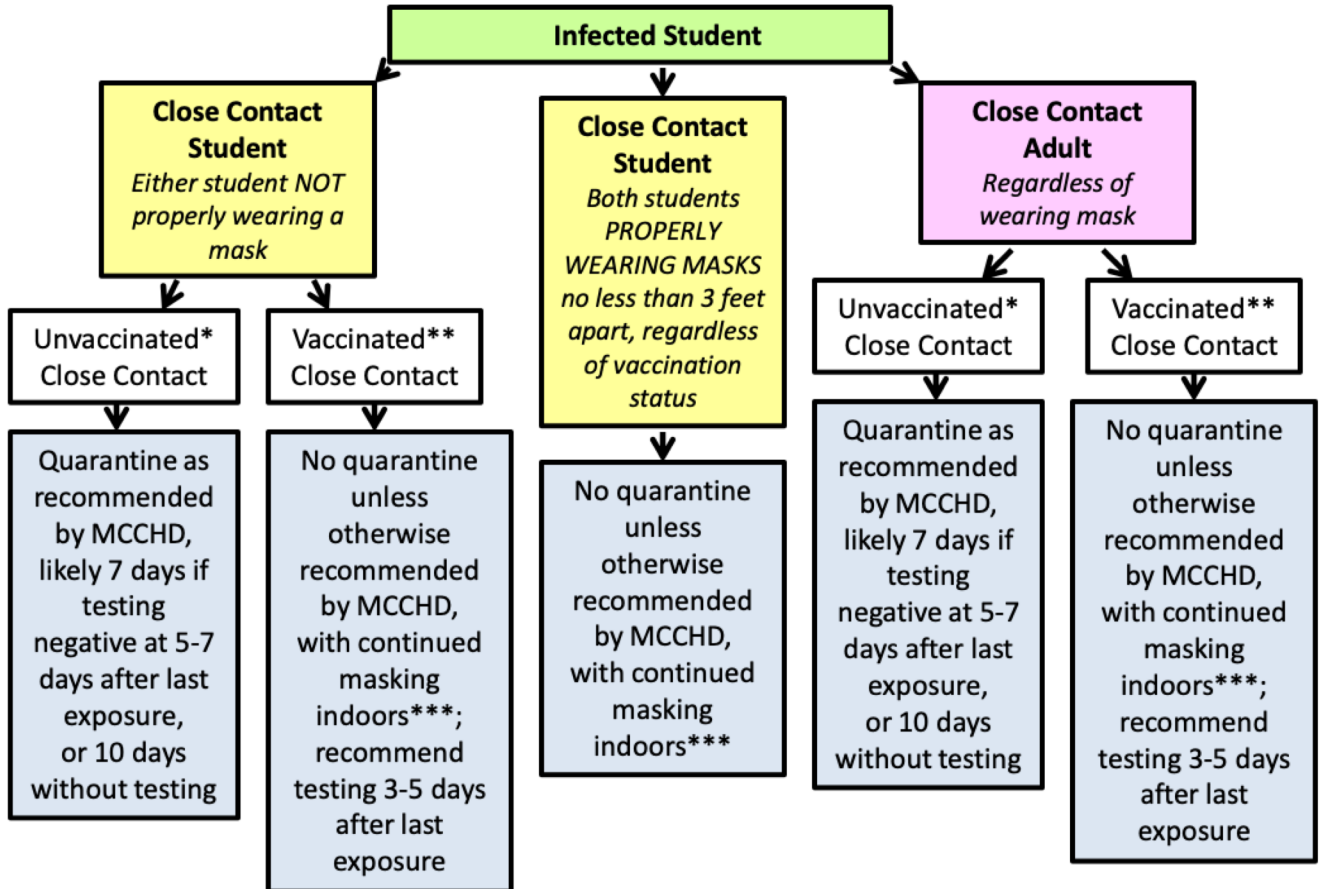
Student: Child enrolled in school

Adult: Staff, visitors, volunteers

Quarantine: Stay at home guidance from health department

Infected: COVID-19 test positive or illness diagnosed to be COVID-19

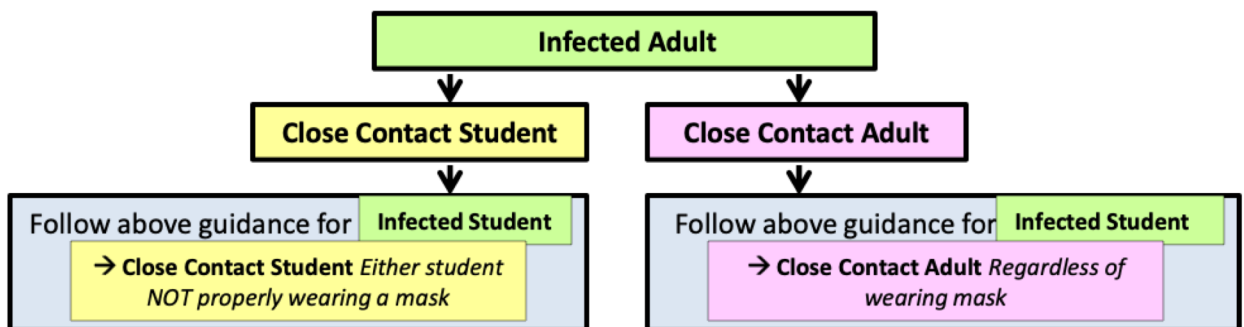
Close Contact only if ASYMPTOMATIC: contact for 15 minutes total within 24 hours and less than 6 feet apart, starting 48 hours before symptoms/test until infected person's isolation is completed; if SYMPTOMATIC: seek testing and/or medical care



*Or vaccination status cannot be confirmed

**Or if you have had COVID-19 illness within previous 3mo AND have recovered AND remain without any COVID-19 symptoms

***Continue wearing mask indoors in public for 14 days following last exposure



<https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html>

<https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html>

<https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html>

LAST UPDATED August 2021

Croup

Croup is a respiratory condition caused by a viral infection. The virus causes swelling of the voice box (larynx) and windpipe (trachea) that makes the airway narrower and hard to breath. Children with croup often develop a harsh, barking cough that makes a noisy, high-pitched sound when they breathe (stridor).

It most often affects children between the ages of 6 months to 5 years old, but can affect older children. Croup can get worse very quickly and if your child has difficulty breathing, seek urgent medical attention.

SYMPTOMS:

Croup often starts without warning, often in the middle of the night. Symptoms are worse at night and often on the 2nd or 3rd night of the illness.

- Starts as a normal viral cold (cough, fever, and runny nose)
- The cough will change sounding more harsh and barking like a seal
- Hoarse voice
- Stridor (when the child breaths in, they make a high pitched, squeaky nose)
- Respiratory distress

TREATMENT:

Use a cool mist humidifier in the child's room and if the breathing gets worse take the child into the bathroom and turn on the shower to increase the humidity and open the window to let cool air into the room. Your doctor may have prescribed an oral steroid medication to take by mouth prior to the child going to sleep. If this does not improve the child's stridor and breathing, then take them to the emergency department where they can do breathing treatments (racemic epinephrine nebulizer) or a steroid given as a shot into the muscle (IM Dexamethasone).

PREVENTION:

- The virus is easily spread from person to person by coughing and sneezing
- If your child has croup, keep them home from school and daycare
- Regular hand washing can help prevent the spread of viruses

MOOD & FEELINGS

PARENT QUESTIONNAIRE

How are you feeling today?



This form is about how you might have been feeling or acting recently. For each question, please check how much you have felt or acted this way in the past two weeks.

Any answer is okay and we can talk about it together.

	NOT TRUE	SOMETIMES	TRUE
1. I felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt so tired I just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I felt I was no good any more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I hated myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I thought nobody really loved me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I thought I could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check any topic below you would like to talk about today:

(you can check none, one, many, or all)

How I feel at home

How I feel at school

How I feel about my friends

How I feel about my body

M O O D & FEELINGS

PAR E N T Q U E S T I O N N A I R E



This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way in the past two weeks.

	NOT TRUE	SOMETIMES	TRUE
1. S/he felt miserable or unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. S/he didn't enjoy anything at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. S/he felt so tired that s/he just sat around and did nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. S/he was very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. S/he felt s/he was no good any more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. S/he cried a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. S/he found it hard to think properly or concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. S/he hated him/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. S/he felt s/he was a bad person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. S/he felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. S/he thought nobody really loved him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. S/he thought s/he could never be as good as other kids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. S/he felt s/he did everything wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Below are questions for me to better understand your child's emotions, behavior, and strengths.

Circle "Yes" or "No" Additionally, you can leave any question blank and/or add comments.

My child feels safe at home YES NO
 My child feels safe at school YES NO

Comments: _____

I can recognize when my child has big emotions YES NO
 My child and I can work together to calm down when upset YES NO

Comments: _____

My child has experienced recent big changes YES NO
 My child has experienced losses in their life YES NO

Comments: _____

There are many activities my child and I enjoy doing together YES NO
 I feel I have the support I need to be a caregiver to my child
 YES NO

Comments: _____



Depression Scoring

Scoring Mood & Feelings Questionnaire:

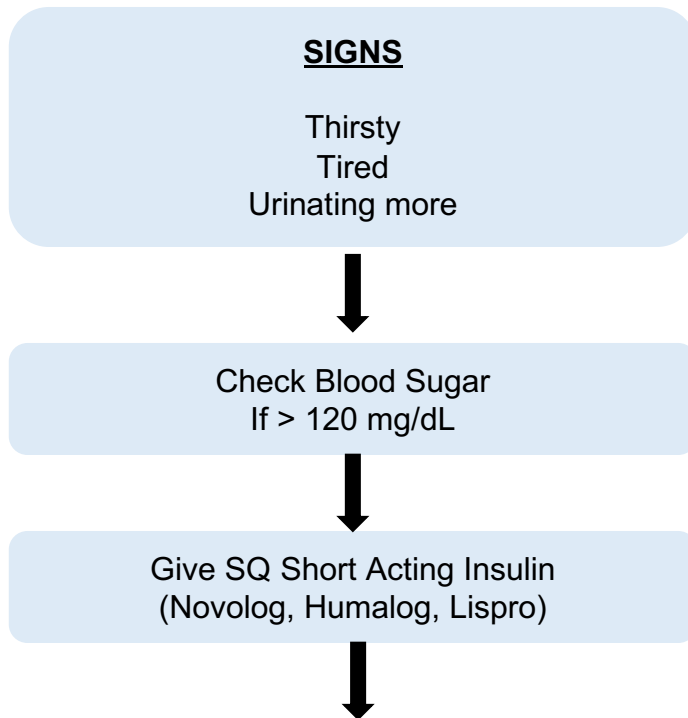
Assign a numerical value to each answer

- Not true = 0
- Sometimes = 1
- True = 2

A total score on the child's version of the SMFQ of 8 or more is significant.

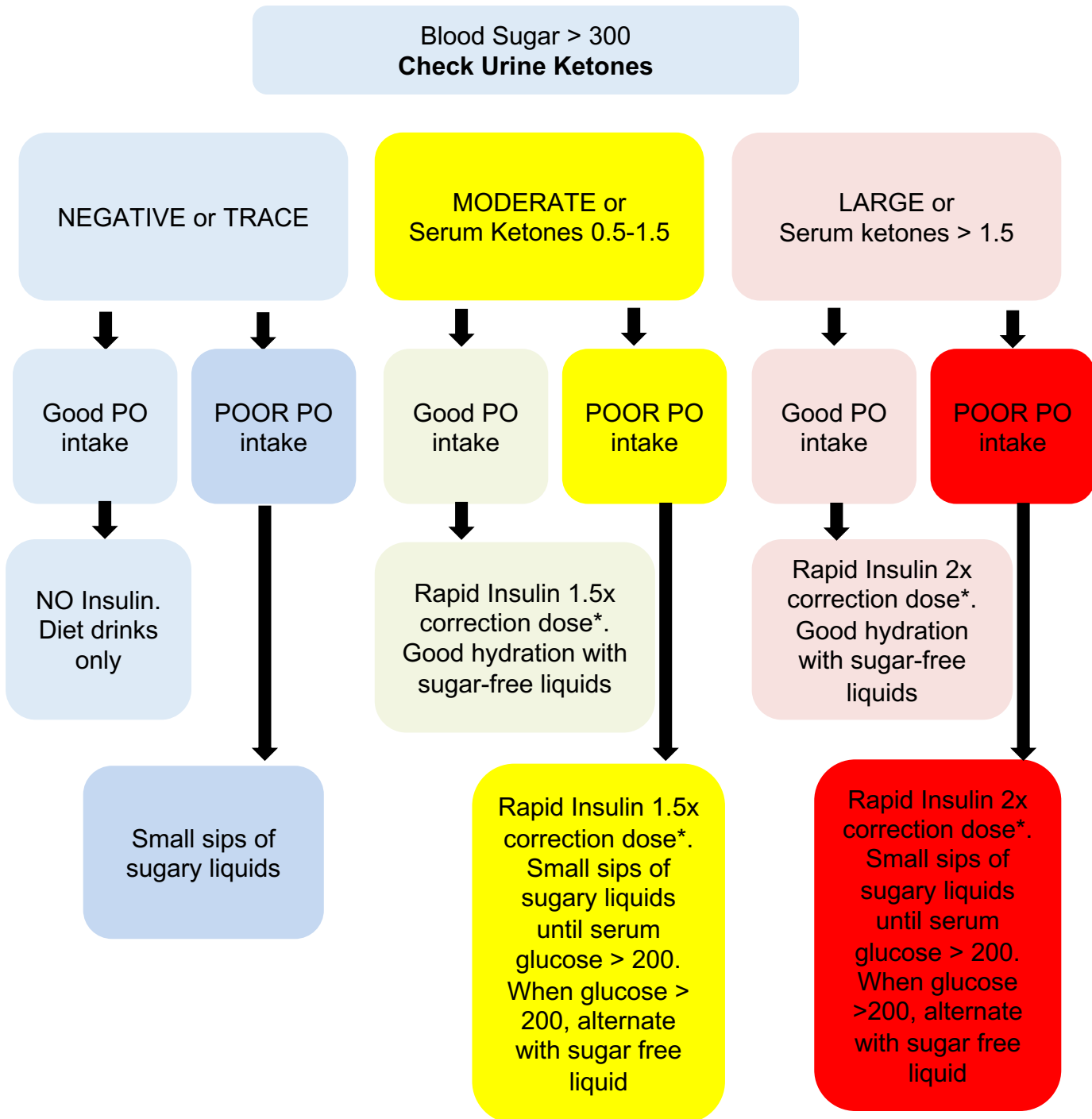
Sensitivity of 60% and specificity of 85% for major depression is at a Cut- off score of 8 or higher.

Diabetes Mellitus- High Sugar



Sliding Scale	
Blood glucose (mg/dL)	Insulin (units)
120-140	1
140-160	2
160-180	3
180-200	4
200-220	5
220-240	6
240-260	7
260-280	8
280-300	9

Diabetes Mellitus-Severe High Sugar



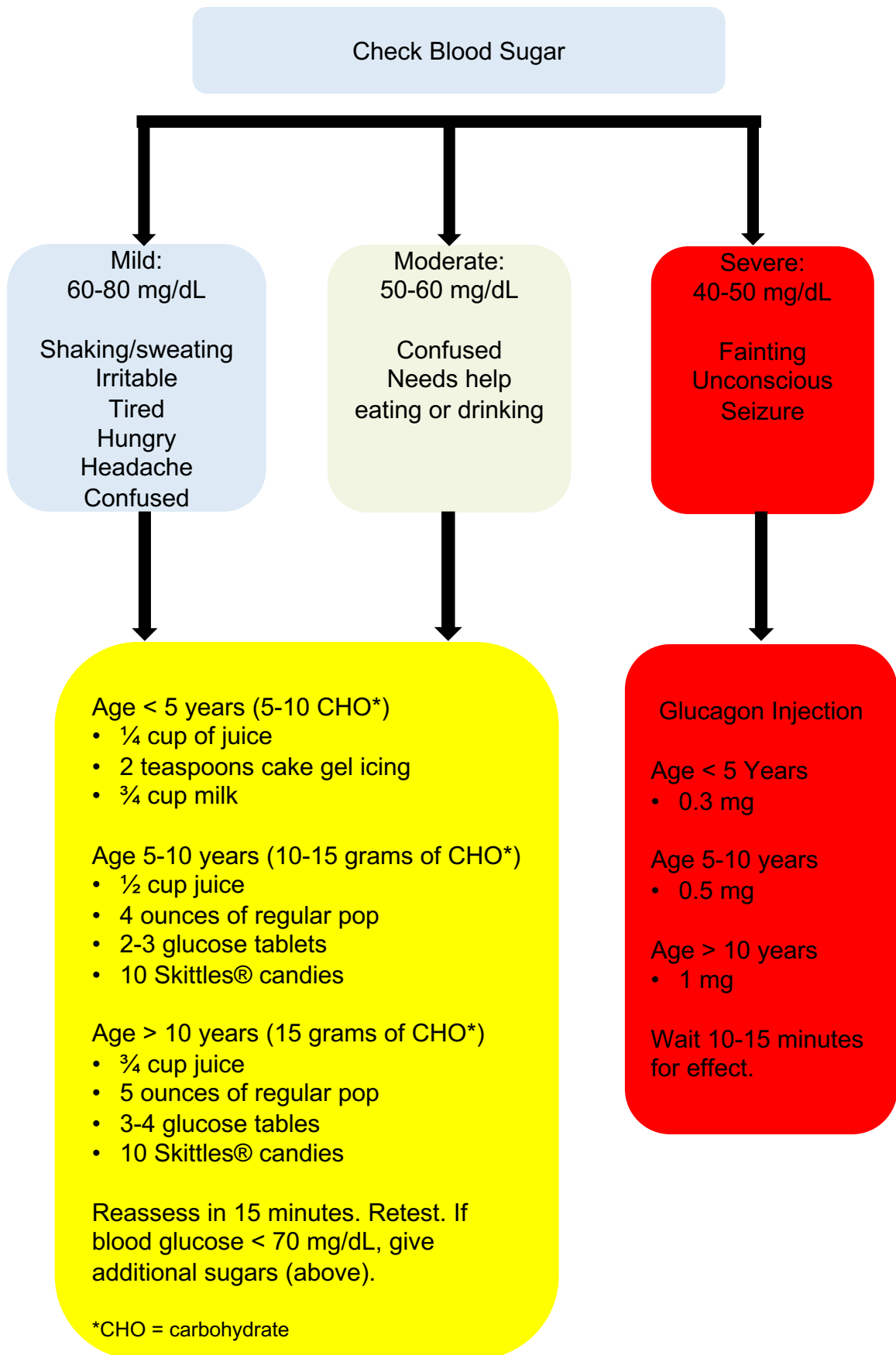
***Correction Factor Example**

Blood glucose = 220 Target = 120 Correction factor = 50

220 (measured blood glucose) – 120 (target) = 100 (amount to be corrected)

100 (amount to be corrected) /50 (correction factor) = 2 (correction dose)

Diabetes Mellitus – Low Sugar



Fever

- possible causes

Otitis media

- Ear pain

Tonsillitis

- Sore throat

Viral

infections

Blood infection

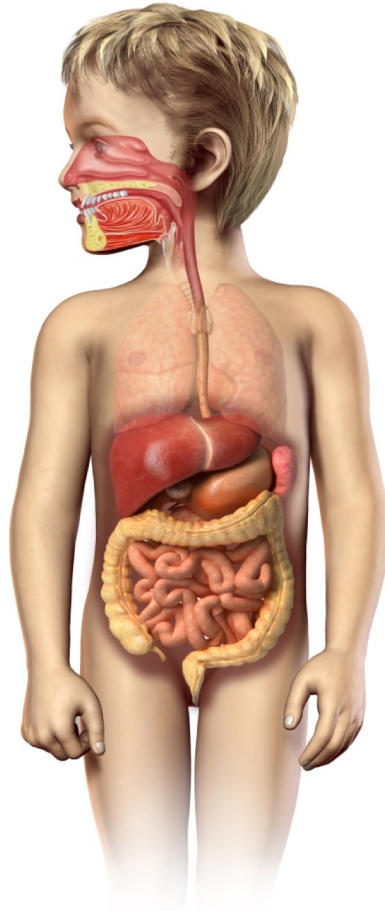
- Streptococcal
- Meningococcal
- Toxic shock

Septic joint

- Joint pain

Viral infection with rash

- Measles
- Chicken pox
- Enterovirus



Upper respiratory infection

- Cough
- Runny nose

Influenza

- Cough
- Headache
- Arthralgia

Pneumonia

- Cough
- Tachypnea

UTI

- Dysuria
- Emesis
- Back pain

Post

vaccine

Kawasaki disease

- Skin peeling, conjunctivitis, cracked lips, pinkeye, rash

HEAD INJURIES

Head injuries can be caused by falls, collisions, car accidents and as a result of child abuse. When a child presents to the clinic with a history of having “bumped” their head or injured themselves in a fall, it is crucial to quickly identify the difference between:

- a minor head injury that needs simple first aid
- an injury that is more serious needing medical evaluation
- an injury that is potentially life threatening

Types of head injuries

SCALP INJURIES: Examples are swelling, bruises, cuts or scrapes. The scalp is very vascular so even a minor scalp injury can cause a big bruise and bump (goose egg). Scalp swelling or bruising alone does not indicate injury to the brain as the skull protects the brain.

SKULL FRACTURES: Some types of skull fractures can be stable. However, a fracture such as a depressed skull fracture or a basilar skull fracture, can cause pressure on the brain and are more serious. Skull fractures that cause bruising around the eyes and clear drainage from nose or ears need to be observed by a provider at hospital.

Brain injuries

A concussion is a mild form of brain injury but can be serious, lasting months or longer. Symptoms that indicate possible concussion include: brief period of confusion or memory loss, dizziness, nausea, prolonged headache, light sensitivity, difficulty concentrating, fatigue, lack of motivation, behavioral changes and irritability.

Bruising, swelling or bleeding are more serious injuries caused by head trauma are more serious. Symptoms can include difficulty waking or keeping awake, neurologic symptoms such as weakness in arms or legs, unsteady gait, slurred speech or confusion.

Assessment of head injury

When a child presents to the clinic with a history of a head injury, obtaining the best history possible is crucial. This should include:

when the injury happened

what was the mechanism of injury (fall from slide, bumped head on wall, etc.)

history of loss of consciousness

identifying witnesses to the event

taking note of the ability of the child to remember events prior to the injury itself

the possibility that child abuse was a factor

how the child was acting prior to and after the injury

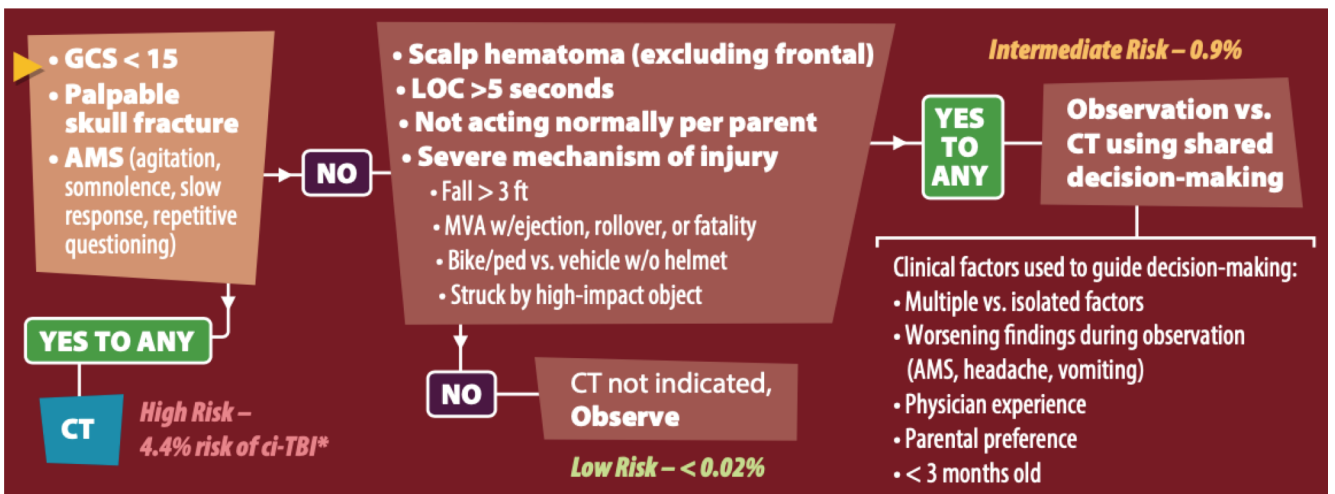
any wounds to head/face/neck or anywhere else

any history of bleeding disorder or bruising easily

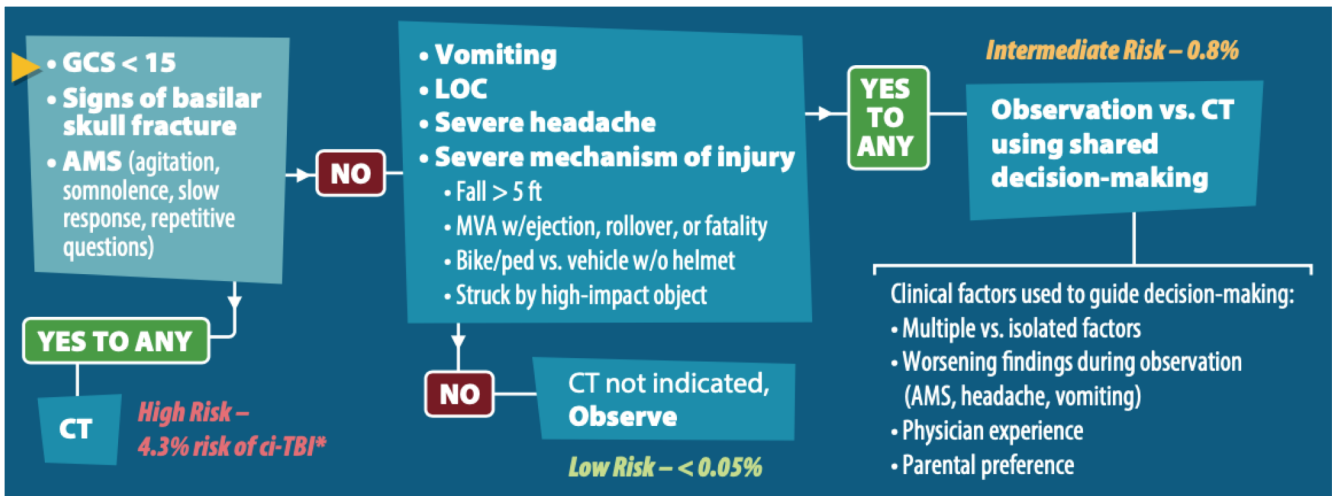
history of developmental or neurologic disorder

CT Scan. When is it needed?

If the child is <2 yrs. old



If the is > 2 yrs. old



HEAD INJURY TRIAGE

Mild

CHILD PRESENTS WITH:

- NO HISTORY OF LOSS OF CONSCIOUSNESS
- IS ALERT AND INTERACTS APPROPRIATELY
- HAS MINOR INJURY LOCALIZED TO SCALP WITH SWELLING OR BRUISE
- MAY HAVE LOCALIZED PAIN
- MAY HAVE CRIED IMMEDIATELY BUT OTHERWISE NORMAL

Child may be treated in clinic
(ice, pressure to wound if bleeding, rest, topical antibiotic and dressing) Guardian should be contacted

Moderate

CHILD PRESENTS WITH:

- HEADACHE, NAUSEA, DIZZINESS, LIGHTEADEDNESS, FOGGY THINKING, FATIGUE, SENSITIVITY TO NOISE OR LIGHT, PROBLEMS WITH CONCENTRATION OR MEMORY, BLURRED VISION
- THERE IS A SUSPICION OF POSSIBLE CHILD ABUSE
- HISTORY OF BLEEDING, DEVELOPMENTAL OR NEUROLOGICAL DISORDERS
- <2 YRS OLD, HISTORY OF CHILD ABUSE OR NECK INJURY

Child needs medical evaluation.
Schedule clinic or telemedicine visit.
Have child answer questions

Severe

CHILD PRESENTS WITH ANY OF THE FOLLOWING:

- WORSENING HEADACHE
- SLURRED SPEECH
- REPEATED DIZZINESS
- VOMITING MORE THAN TWICE
- DIFFICULTY WALKING
- DIFFICULTY WAKING UP
- UNEQUAL PUPILS
- SEIZURES
- CONFUSION
- OOZING BLOOD OR CLEAR LIQUID FROM NOSE OR EARS
- MAJOR BLEEDING THAT CAN'T BE STOPPED
- LOSS OF CONSCIOUSNESS FOR MORE THAN 1 MINUTE
- NECK STIFFNESS OR PAIN (PROTECT NECK FOR MOVEMENT)

Child needs immediate help. Call 911 or take to the ER

Hypertension

Hypertension is blood pressure (BP) that is higher than normal. Blood pressure is the pressure of blood pushing against the walls of your arteries. Arteries are what carry your blood from your heart to other parts of your body. In children younger than 13, we determine if they have hypertension based on their age and height. In children older than 13, we use the adult guidelines ($> 120/80$).

Why screen for hypertension?

It is normal for BP to rise and fall throughout the day, but if it stays too high for too long, this can cause damage to body organs like the heart and kidneys. Children who experience hypertension generally do not experience negative effects immediately (like heart attack and stroke). But we do know that long-term hypertension in children puts them at higher risk for these negative events in adulthood. Monitoring children for hypertension and intervening early can provide better outcomes for them later in life.

When to screen for hypertension?

The American Academy of Pediatrics (AAP) recommends that all children be screened for hypertension once a year after the age of 3. The AAP also recommends that children be screened at every office visit if they have obesity, are taking medications that could increase BP, or have other high-risk factors for hypertension, like diabetes or kidney disease.

In the SBHC, we have the opportunity to take each child's BP at every visit, which could help us to identify children with hypertension who may not have been diagnosed yet.

How to screen for hypertension?

The AAP has provided a chart that can be used at each office visit to quickly identify the children who should be further assessed for hypertension:

Hypertension-cont'd

BP values requiring further evaluation (BP mmHg)

Age, y	Boys-Systolic	Boys-Diastolic	Girls-Systolic	Girls-Diastolic
1	98	52	98	54
2	100	55	101	58
3	101	58	102	60
4	102	60	103	62
5	103	63	104	64
6	105	66	105	67
7	106	68	106	68
8	107	69	107	69
9	107	70	108	71
10	108	72	109	72
11	110	74	111	74
12	113	78	114	75
13 and older	120	80	120	80

If you are triaging a patient and their BP is higher than the value listed in the chart for their age, it is first a good idea to repeat taking the blood pressure using a manual cuff and ensuring good practices (for example, child is calm, correct cuff size, etc). If the reading is still elevated, please notify the provider.

Depending on the situation, the provider will probably want the child to schedule a follow-up appointment to have their BP checked again.

Hypertension is diagnosed after 3 separate elevated readings.

How to treat hypertension in children?

Lifestyle changes are usually the first interventions (i.e. improved diet, exercise). If after 6-12 months the BP is still elevated, medication may be considered as a form of treatment. Regular readings are also important to monitor whether the BP is trending up or down.

Influenza

Sudden onset of any of the following:

Fever
Cough
Sore throat
Runny or stuffy nose
Headache
Fatigue
Vomiting and/or diarrhea

Influenza **POSITIVE**
TEST
(A or B)

Influenza **NEGATIVE**
TEST

INFECTION LIKELY

May not be reliable or
accurate

- Begin antiviral meds*
- Initiate infection control
- Consider need for additional testing for bacterial co-infections

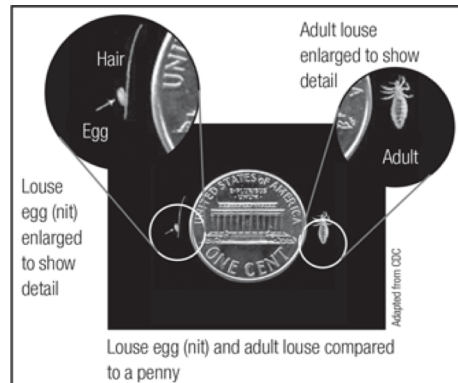
- If clinical presentation consistent with influenza, initiate antiviral meds*
- Consider additional influenza testing
- Consider testing for bacterial co-infections

***Oseltamivir** (Tamilflu)
2 weeks-1 year: 3 mg/kg BID for 5 days
1-12 years of age:
≤15 kg: 30 mg BID
15.1 kg- 23 kg: 45 mg BID for 5 days
23.1-40 kg: 60 mg BID for 5 days
>40.1 kg: 75 mg BID for 5 days

Lice

HEAD LICE (Pediculosis Capitis):

Head lice are tiny bugs about the size of a sesame seed (2–3 mm long). Their bodies are usually pale and gray, but their color may vary. One of these tiny bugs is called a louse. Head lice feed on small amounts of blood from the scalp. They can usually live 1 to 2 days without blood meal. Lice lay and attach their eggs to hair close to the scalp.



The eggs and their shell casings are called nits. They are oval and about the size of a knot in thread (0.8 mm long and 0.3 mm wide) and usually yellow to white. Some nits may blend in with some people's hair color, making them hard to see, and are often confused for dandruff or hair spray droplets. Nits attach to the hair with a sticky substance that holds them firmly in place. After the eggs hatch, the empty nits stay on the hair shaft.

Lice commonly affect school-aged children and their families. It can affect anyone and has nothing to do with being clean or dirty. Head lice affect all socioeconomic groups.

Head lice are crawling insects. They cannot jump, hop, or fly. The fundamental way head lice spread is from close, prolonged head-to-head contact. It is unlikely that head lice will spread by sharing items such as combs, brushes, and hats. Away from the scalp, head lice survive < 1 day at room temperature and their eggs are non-viable in 1 week. Pets do not play a role in head lice.

Itching of the scalp is the most common symptom of lice. Itching primarily happens behind the ears or at the back of the neck. Excoriations and crusting can be found on the ears and nape of the neck, and regional lymphadenopathy. Some children are asymptomatic, though. Also, itching caused by head lice can last for weeks, even after they have eliminated the lice.

Lice—cont'd

How do you check for head lice?

- Seat the child in a brightly lit room
- Part the hair and look for crawling lice and nits one section at a time
- Live lice are hard to find. They avoid light and move quickly.

Nits will look like small white or yellow-brown specks and be firmly attached to the hair near the scalp. The easiest place to find them is at the hairline, at the back of the neck or behind the ears. Nits can be confused with many other things such as dandruff, dirt particles, or hair spray droplets. The way to tell the difference is that nits are firmly attached to hair, while dandruff, dirt, or other particles are not.

Treatment:

Once the diagnosis of lice is confirmed, treatment with an OTC solution is started (see table below). There is some documented resistance to clinical OTC solutions, so if persistent infestation, a prescription medicine should be started. It is important to meticulously "comb-out" the hair besides the above treatments.

Of note, none of the "usual" treatments for lice (per the Red Book) are on the IHS formulary. In speaking with the Ft Peck nurses, tea tree oil products are most commonly used and seem to be effective. There is limited data for this treatment.

Here is how to use the comb-out method:

Step 1: Wet the child's hair.

Step 2: Use a fine-tooth comb and comb through the child's hair in small sections.

Step 3: After each comb-through, wipe the comb on a wet paper towel. Examine the scalp, comb, and paper towel carefully.

Step 4: Repeat steps 2 and 3 until you've combed through all of your child's hair.

In addition:

There is some limited benefit in washing the child's clothes, towels, hats, and bed linens in hot water and dry on high heat if they were used within 2 days before head lice were found and treated.

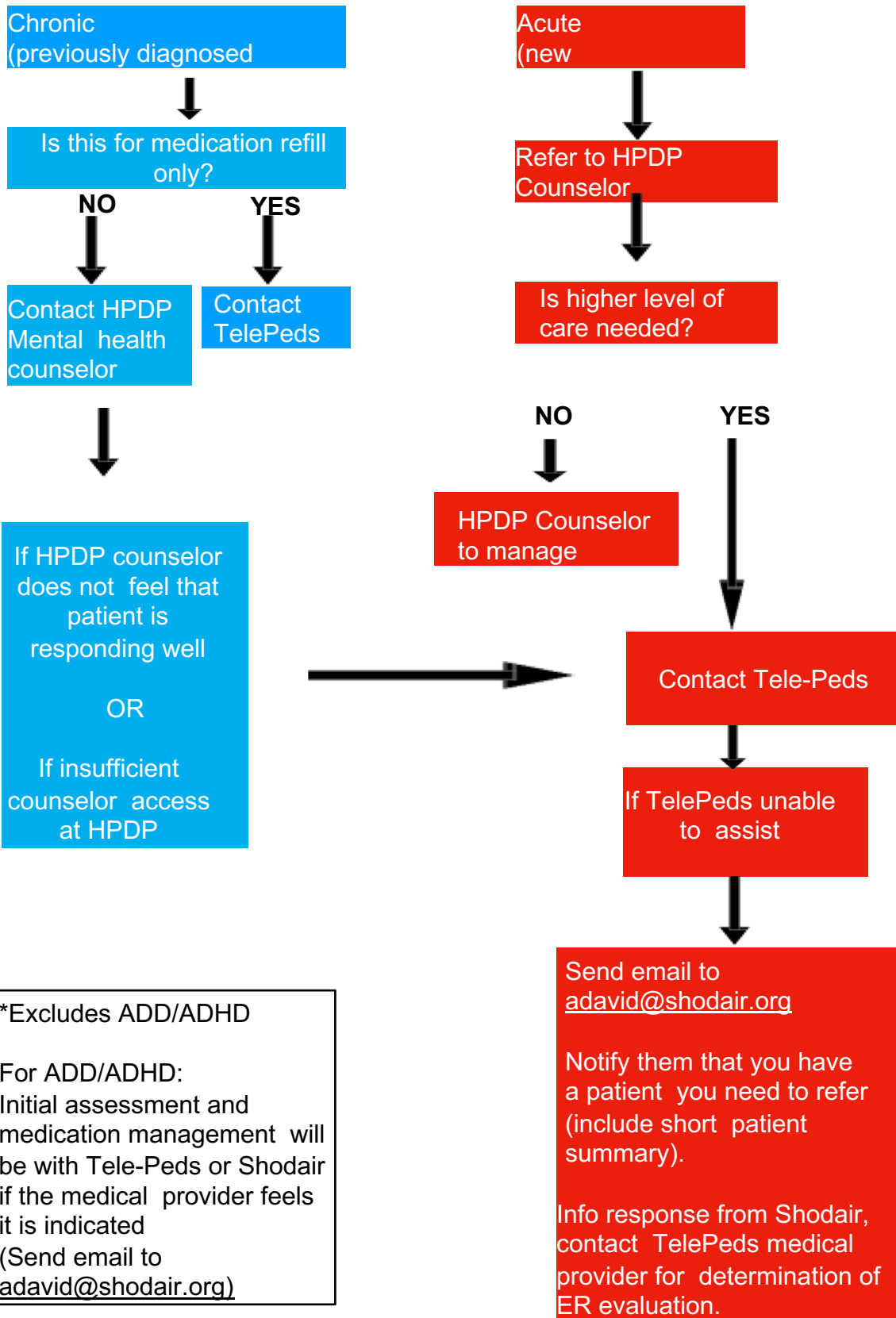
You do not need to throw these items away. Items that cannot be washed may be dry-cleaned or sealed in a plastic bag for 2 weeks, such as stuffed animals.

All household members and close contacts should also be checked and treated.

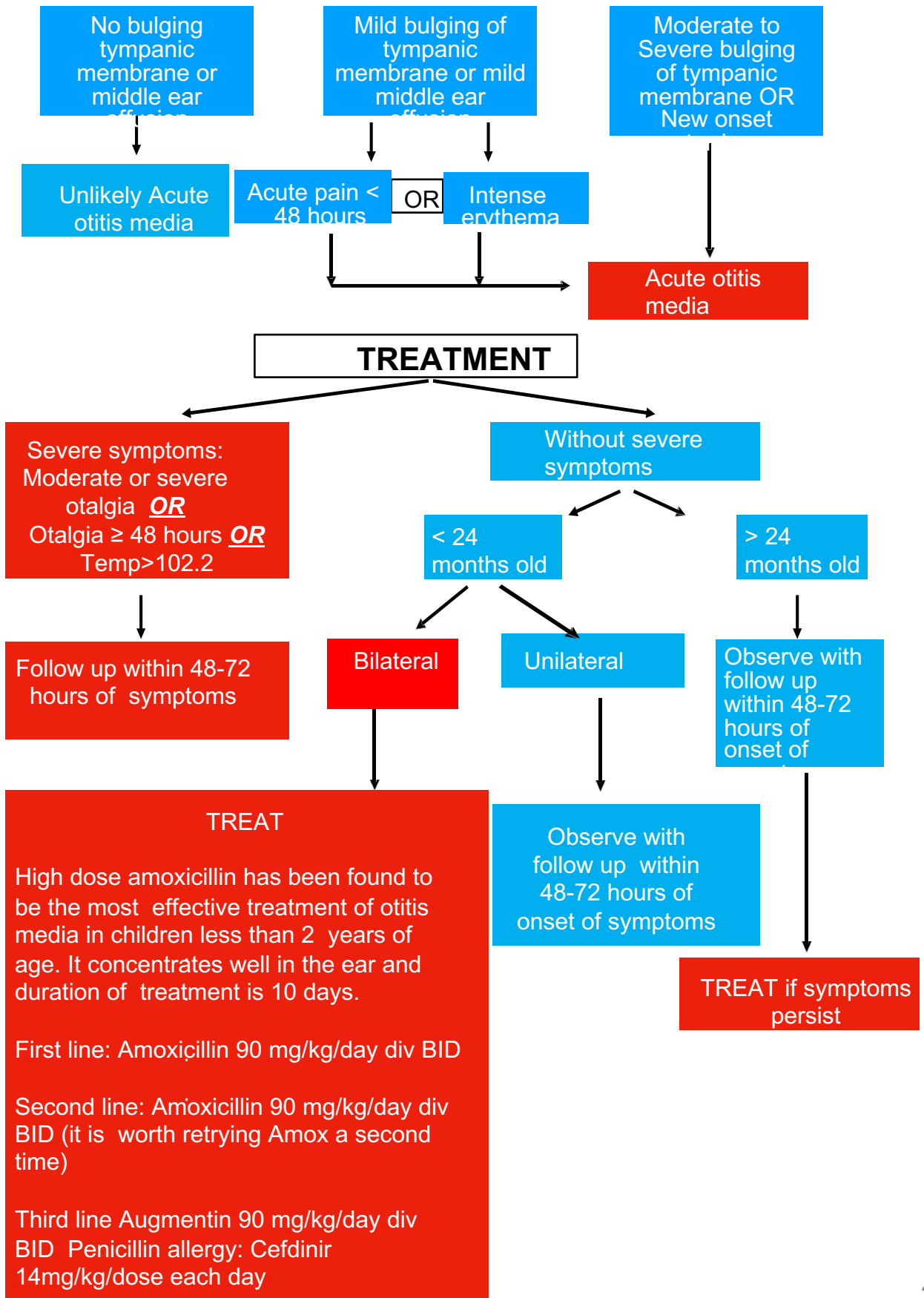
School and "no-nit" policies:

The American Academy of Pediatrics and National Association of School Nurses discourage such policies and believe a child should not miss or be excluded from school because of head lice.

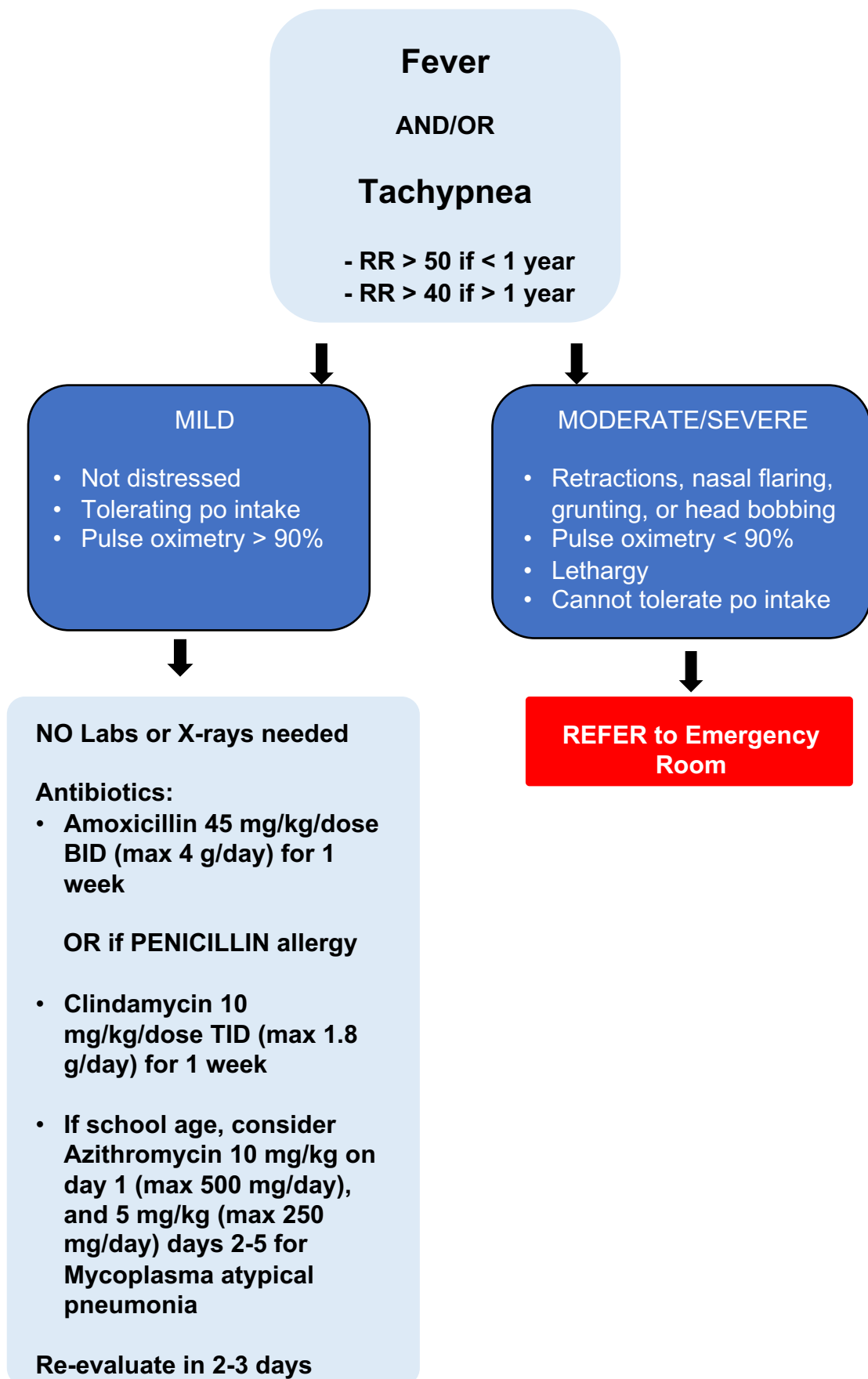
Mental Health Decision Tree*



Otitis Media Decision Tree



Pneumonia – Community Acquired



Ringworm

Ringworm is an itchy rash caused by a fungus and gets its name from the ring-shaped appearance on the skin. It is often named for where it is located on the body and therefore has other names such as athlete's foot (ringworm of the feet) and jock itch (ringworm of the groin). Ringworm is NOT caused by a worm as the name may suggest.

SYMPTOMS:

- Red, itchy rash with central clearing on the scalp, face, body, groin, feet or hands

TREATMENT:

Treatment is based on the location of the rash and typically is an antifungal cream such as clotrimazole 1% cream applied to the site of infection on the body or antifungal pills such as griseofulvin that can be taken by mouth when the infection is located on the scalp.

PREVENTION:

- You can get ringworm from people, animals (especially cats), or places (wrestling mats)
- Keep your skin, hair, and nails clean and dry
- Do not share towels, clothing, or hairbrushes
- Wash towels and clothing in hot water and soap to destroy the fungus
- Keep common use areas clean
- If you have athlete's foot, stay away from common areas such as community pools and gyms until the infection has resolved

Suicide Risk Decision Tree

ASK 4 QUESTIONS:

"In the past month, have you wished you were dead?"

"In the past month, have you felt that you or your family would be better off if you were dead?"

"Have you ever tried to kill yourself?"

"In the past week, have you had thoughts about killing yourself?"

ALL answers are NO

LOW RISK

ANY YES answer OR child refuses to answer

"Are you thinking of killing yourself right now?"

NO

POTENTIAL RISK

Needs suicide safety assessment by LSW / psych for determination of need for full mental health evaluation

Keep student until evaluation complete, to determine disposition

Alert medical provider of status

YES

IMMINENT RISK

**Keep student in sight
Remove dangerous objects from room**

Transfer for STAT safety evaluation and full mental health evaluation by psychiatric provider

Alert medical provider of status

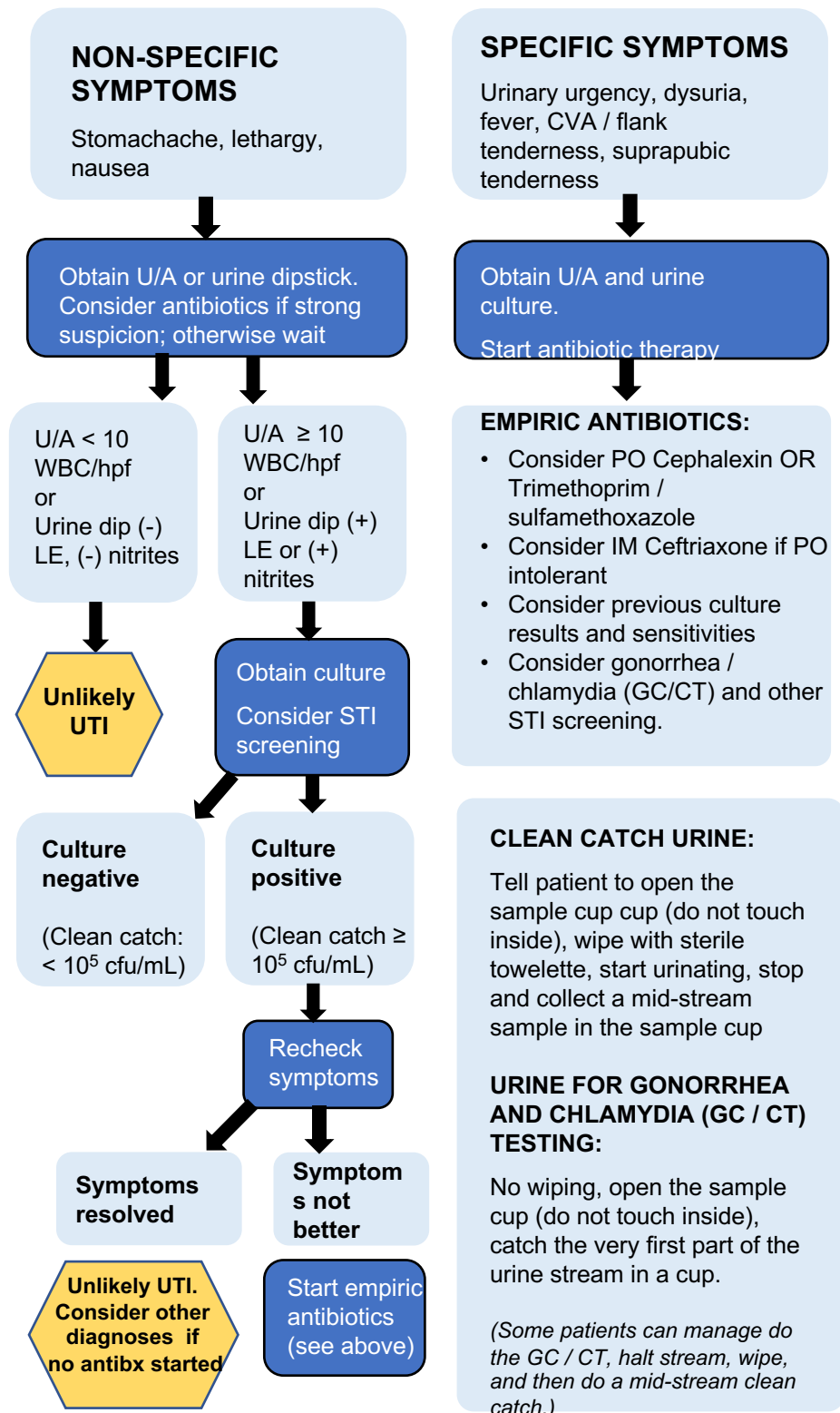
Transfer options:

St Vincent HealthCare (Billings)
Direct transfer to inpatient; call 406 237 8775

Shodair (Helena)
Child must be transferred to nearest ER. Medical professional must evaluate and determine desire for inpatient services; call 406 444 7516.

Billings Clinic (Billings):
Child can be directly admitted from Ped clinic. Medical professional must evaluate and determine need for inpatient services; call 406 238 2500.

Urinary Tract Infection



Wart

Definition = raised, round, rough-surfaced growth on the skin found most commonly on the hands and bottom of feet (plantar wart). Caused by a virus (papillomaviruses) and expected to disappear without treatment in 2 to 3 years. They are harmless and there are no shortcuts in treating a wart. With treatment a wart will resolve in 2 to 3 months.



Home treatment:

- 1) Soak the wart in warm water for 5 minutes (after bath or shower works great!)
- 2) Remove dead wart material – rubbing with a pumice stone or a foot callus scraper (can buy at a drugstore)
- 3) Buy liquid over-the-counter wart medication with salicylic acid (Wort off, Compound W, Clear away) and apply to the wart daily.



- 4) Cover the wart with duct tape after applying wart medicine.
- 5) Repeat medication application + Band-Aid or duct tape daily.

Contagiousness = Encourage your child not to pick at the wart because it may spread. If your child chews or sucks the wart, cover it with a Band-Aid and change it daily. Chewing on warts can cause warts to develop on the lips or face. Warts are not very contagious to other people, though they can be spread on feet if barefoot at locations like pools.

Follow-up with the pediatrician if:

- Warts develop on the feet, genitals, or face
- Wart becomes open and looks infected
- New warts develop after 2 weeks of treatment
- Warts are still present after 8 weeks of treatment

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WARTS

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