**Children’s Oral Fluid Challenge**

Dear Parent / carer,

Your child needs to drink fluid in order to prevent dehydration.

Date ................................................................................

Name ..............................................................................

ED Number/ Hospital ....................................................

Number/ NHS Number ...................................................

Dob ..................................................................................

Weight ...........................................................................

Please give your child ………… ml of the suggested fluid, measured using the syringe provided every ten minutes.

You need to tick the boxes below each time your child has a drink, and also mark down if your child vomits or has diarrhoea.

Show this chart to the Doctor when your child is seen.

Thank you.

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| --- | --- | --- |
| Time | Fluid given (tick please) | Vomit or diarrhoea? |
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