MODE OF ARRIVAL:
Private automobile.

CHIEF COMPLAINT:
Fever.

HISTORY OF PRESENT ILLNESS:
This patient is a 17-month-old male, whose caretakers report that the child developed a fever at 1900 hours last night, and was medicated with Tylenol at 1930 hours. The child later woke up at 2315 hours crying, with a "barking, croupy cough", and shortness of breath. The child was taken to the bathroom with humidified air, and had a significant improvement with this. The child has had no further respiratory distress. The caretakers also report a prodrome over the last several days, consisting of a runny nose, congestion, and cough. His temperature maximum today was 101.2. The child has had no ear-tugging. The child has had intermittent hives over the last 3 weeks, and has been medicated with Benadryl with this. The child has been tolerating p.o. intake, with no vomiting or diarrhea. He has had a normal urinary output. The child has been more fussy, but not lethargic.

REVIEW OF SYSTEMS:
CONSTITUTIONAL/RESPIRATORY: As above. All other systems were reviewed and are negative.

PAST MEDICAL HISTORY:
None.

PAST SURGICAL HISTORY:
None.

MEDICATIONS:
1. Tylenol.
2. Benadryl.

ALLERGIES:
NKDA.

SOCIAL HISTORY:
None.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 101.3 rectally, pulse of 143, respirations were 28 in triage, approximately 20 upon my examination, pulse oximetry 96% on room air.
GENERAL APPEARANCE: The patient is awake, alert, well-appearing, nontoxic, and in absolutely no respiratory distress (status post receiving racemic epinephrine treatment).
HEENT: Oropharynx mucous membranes are moist, and is otherwise clear.
NECK: Supple, with no meningismus.
LUNGS: Clear to auscultation bilaterally, with no rales, rhonchi, or wheezes.
CARDIOVASCULAR: Tachycardia and regular, normal S1 and S2 heart sounds.
ABDOMEN: Soft, nontender, and nondistended.
EXTREMITIES: Peripheral pulses are all equal. Capillary refill less than 2 seconds.
SKIN: Warm and dry.
NEUROLOGICAL: Interacts appropriately for age, good strength and tone.

DIAGNOSTIC STUDIES:
None, based on history and physical.

EMERGENCY DEPARTMENT COURSE:
The child's condition had improved during the emergency department stay. The child was medicated with racemic epinephrine prior to my examination. The patient's saturations were in the high 90s on

room air, in no respiratory distress, with no accessory muscle use, and clear breath sounds. The child was medicated with Decadron 0.6 mg/kg. Upon multiple reexaminations thereafter, the patient was resting comfortably, in no respiratory distress, with room-air pulse oximetries in the mid to high 90s.

CLINICAL ASSESSMENT:
1. Laryngeal tracheobronchitis (croup).
2. Acute febrile illness, secondary to number 1.

DISPOSITION:
1. The patient will be discharged to home, and will have follow-up with his primary medical doctor within 48 hours.
2. The patient is to return to the emergency department for any worsening dyspnea.
3. The patient was in good condition at the time of discharge.