PELC
Partnership of East London Co-operatives Ltd

Children's Oral Fluid Challenge

Name:.....

Hospital Number: .....

DOB:.....

Date: Weight (kg):	Fluid Volume: 50mls/kg = ...mls total over 4 hours Total/24 = ...mls every 10 mins

Dear parent/carer,

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

Please give your child .....mls of the suggested fluid **every ten minutes** as you have been shown. 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 nurses and doctors who come to see your child. If you have any problems doing this, or are worried about your child while you are waiting, please speak to any of the staff in the department.

Time	Fluid given (tick)	Vomit/Diarrhoea?

Name of assessing professional .....Signature.....