Information Needed

1. History: sudden or gradual onset, cough, fever, sore throat, hoarseness, past medical history, medications.
2. Physical findings: LOC, air movement, lung sounds, respiratory rate and effort, retractions, use of accessory muscles, stridor, cough, wheezing, crackles, leaning forward or drooling, skin color and temperature.

Treatment

1. As long as the child is adequately ventilating and mentating, avoid agitating patient in any way.
2. Allow child to assume position of comfort and supplement blow-by O_2 if child will accept it.
3. If child is not ventilating adequately:
   a. Assist ventilation with BVM with 100% O2.
   b. If and only if patient cannot be ventilated with BVM:
      i. Visualize airway and remove foreign body with Magill forceps.
      ii. If nothing is seen intubate the patient.
4. If you suspect croup or epiglottitis:
   a. Begin by nebulizing normal saline
   b. If symptoms do not improve, consider an epinephrine or racemic epinepherine neb.
5. If reactive airway disease is present, administer albuterol neb(s).

Notes

1. Pediatric respiratory distress is a critical situation that can be made worse by prolonged scene time.
2. Respiratory arrest is usually due to exhaustion. Most children can be ventilated with a BVM.