



PEDIATRIC ASSESSMENT



Updated 2011

General Impression

(First view of patient)

Airway & Appearance (Open/Clear – Muscle Tone /Body Position)

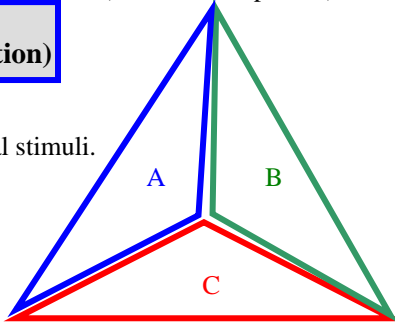
Abnormal: Abnormal or absent cry or speech. Decreased response to parents or environmental stimuli. Floppy or rigid muscle tone or not moving.

Normal: Normal cry or speech. Responds to parents or to environmental stimuli such as lights, keys, or toys. Good muscle tone. Moves extremities well.

Work of Breathing (Visible movement / Respiratory Effort)

Abnormal: Increased/excessive (nasal flaring, retractions or abdominal muscle use) or decreased/absent respiratory effort or noisy breathing.

Normal: Breathing appears regular without excessive respiratory muscle effort or audible respiratory sounds.



Circulation to Skin (Color / Obvious Bleeding)

Abnormal: Cyanosis, mottling, paleness/pallor or obvious significant bleeding.
Normal: Color appears normal for racial group of child. No significant bleeding.

Decision/Action Points:

- **Any abnormal findings or life-threatening chief complaint** such as major trauma/burns, seizures, diabetes, asthma attack, airway obstruction, etc (urgent) – proceed to Initial Assessment. Contact ALS if ALS not already on scene/enroute.
- **All findings normal** (non-urgent) – proceed to Initial Assessment.

Initial Assessment

(Primary Survey)

Airway & Appearance (Open/Clear – Mental Status)

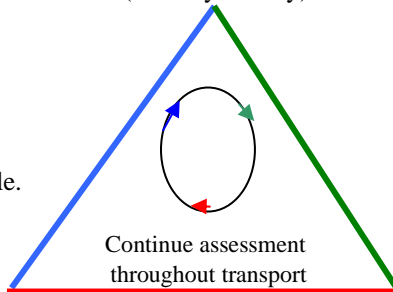
Abnormal: Obstruction to airflow. Gurgling, stridor or noisy breathing. Verbal, Pain, or Unresponsive on AVPU scale.

Normal: Clear and maintainable. Alert on AVPU scale.

Breathing (Effort / Sounds / Rate / Central Color)

Abnormal: Presence of retractions, nasal flaring, stridor, wheezes, grunting, gasping or gurgling. Respiratory rate outside normal range. Central cyanosis.

Normal: Easy, quiet respirations. Respiratory rate within normal range. No central cyanosis.



Circulation

(Pulse Rate & Strength / Extremity Color & Temperature / Capillary Refill / Blood Pressure)

Abnormal: Cyanosis, mottling, or pallor. Absent or weak peripheral or central pulses; Pulse or systolic BP outside normal range; Capillary refill > 2 sec with other abnormal findings.

Normal: Color normal. Capillary refill at palms, soles, forehead or central body ≤ 2 sec. Strong peripheral and central pulses with regular rhythm.

Decision/ Action Points:

- **Any abnormal finding** – Immediate transport with ALS. If ALS is not immediately available, meet ALS intercept enroute to hospital or proceed to hospital if closer. Open airway & provide O₂. Assist ventilations, start CPR, suction, or control bleeding as appropriate. Check for causes such as diabetes, poisoning, trauma, seizure, etc. Assist patient with prescribed bronchodilators or epinephrine auto-injector or administer meds if approved and appropriate.
- **All findings on assessment of child normal** – Continue assessment, detailed history & treatment at scene or enroute.

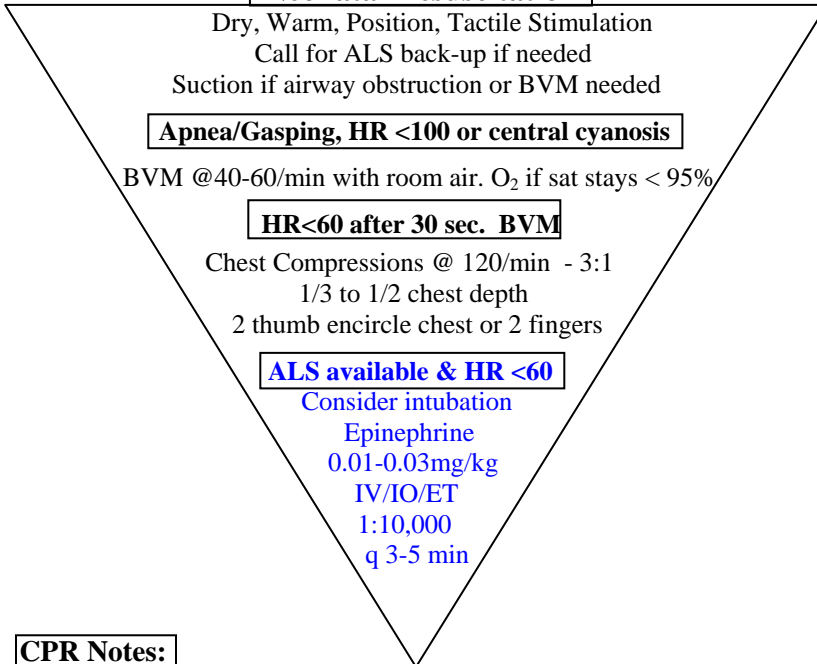
Normal Respiratory Rate:	Normal Pulse Rate:	Lower Limit of Normal Systolic BP:
Infant (<1yr): 30- 60	Infant: 100-160	Infant: >60 (or strong pulses)
Toddler (1-3yr): 24 -40	Toddler: 90-150	Toddler: >70 (or strong pulses)
Preschooler(4-5yr): 22- 34	Preschooler: 80-140	Preschooler: >75
School-age(6-12yr): 18 -30	School-age: 70-120	School-age: >80
Adolescent(13-18yr): 12 -20	Adolescent: 60-100	Adolescent: >90
	Pulses slower in sleeping child / athlete	Estimated min.SBP >70 + (2 x age in yr)

This reference card should NOT replace or supersede regional prehospital medical treatment protocols.

APGAR Score

	0 pt	1 pt	2 pts
Appearance	Blue	Pink Body Blue Limbs	All Pink
Pulse	Absent	<100	≥100
Grimace/Reflex	None	Grimace	Cough/Sneeze
Activity	Limp	Some flexion	Active motion
Respirations	Absent	Slow/Irregular	Good

Neonatal Resuscitation



CPR Notes:

- Start CPR for cardiac arrest or HR<60 with poor perfusion.
- AEDs with pediatric capabilities preferred if patient < 25kg or 55lb (<8 yr old). If unavailable, may use adult AED.
- Do not pause CPR for more than 10 sec. for pulse checks, intubation, patient transfer or other reasons. Give medications during CPR whenever possible.

Pediatric ALS Guidelines

Asystole or PEA

Start CPR
Intubate if needed to maintain airway.

Epinephrine: 0.01 mg/kg 1:10,000 IV/ IO
0.1 mg/kg 1:1000 ET
Continue Epinephrine q 3-5 min, same dose

Bradycardia

Open airway & ventilate with oxygen.
Intubate if needed to maintain airway and decreased consciousness
Start CPR if HR<60 with poor perfusion.

Epinephrine: 0.01 mg/kg 1:10,000 IV/ IO
0.1 mg/kg 1:1000 ET
Continue Epinephrine q 3-5 min, same dose

Atropine 0.02 mg/kg IV/ IO
0.03 mg/kg ET
minimum dose 0.1 mg
maximum dose 0.5 mg child; 1 mg adol.
Consider transcutaneous pacing as needed.

VF or Pulseless VT

Defibrillate 2j / kg (after 2 min CPR)
Continue CPR, ventilate with O₂ ;
Intubate if needed to maintain airway,
Epinephrine: 0.01 mg/kg 1:10,000 IV/ IO
(q3-5 min) 0.1 mg/kg 1:1000 ET
Defibrillate 4j / kg; Resume CPR immed.
Amiodarone 5mg/kg IV/IO (pref) or
Lidocaine 1mg / kg IV/ IO/ ET
Defibrillate 4-10 J/kg q 2 min as needed
(up to adult dose)
Use Magnesium 25-50mg/kg IV/ IO if torsades de pointes or hypomagnesemia

Consider possibility of hypoxia, hypovolemia, hypothermia, hydrogen ion (acidosis), hyper/hypokalemia, hypoglycemia, tamponade, tension pneumothorax. toxins/poisons/drugs. trauma or thrombosis (coronary or pulmonary) and treat if present.

Glasgow Coma Score

		Children /Adults
Infants		
Eye Opening		
Spontaneous	4	Spontaneous
To speech/sound	3	To speech
To pain	2	To pain
No response	1	No response
Verbal Response		
Coos or babbles	5	Oriented
Irritable crying	4	Confused
Cries to pain	3	Inappropriate words
Moans to pain	2	Incomprehensible
None	1	None
Motor Response		
Spontaneous	6	Obeys commands
Withdraws touch	5	Localizes pain
Withdraws pain	4	Withdraws pain
Abnormal flexion	3	Abnormal flexion
Abnormal extension	2	Abnormal extension
No response	1	No response

Respiratory or Cardiac Arrest

	Infant 20/min	Child 12-20/min	Adol/Adult 12/min
VENT RATE Patient with pulses			
COMPRESS METHOD	Encircle or 2 fingers	1 or 2 hands	2 hands
DEPTH	1/3 (1 1/2 in)	1/3 (2 in)	at least 2 in
COMPRESS RATE(minimum)	100/min	100/min	100/min
C:V RATIO (2 people)	15:2	15:2	30:2
Push HARD & FAST, allow full chest RECOIL!			

- Do not synchronize ventilations/compressions after intubation - ventilate at 8-10/min when no pulses.
- After defibrillation, do 2 full minutes of CPR starting with compressions before pulse/rhythm check.
- Adolescent/Adult protocols apply to patients with obvious signs of puberty (breast development obvious through clothing, facial hair, etc), acne, adult appearance/size, or visible axillary hair