



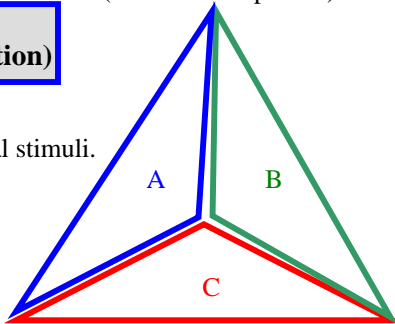
PEDIATRIC ASSESSMENT



2007 version

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)

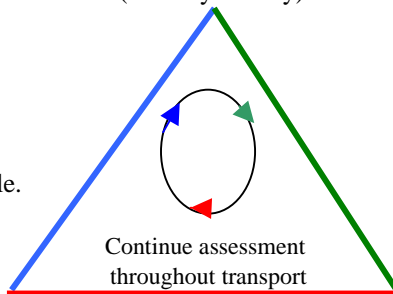
Abnormal: Cyanosis, mottling, paleness/pallor or obvious significant bleeding.
Normal: Color appears normal for racial group of child. No significant bleeding.

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 (C, U, or P)**– 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 (S)**– Continue assessment, detailed history & treatment at scene or enroute.

Normal Respiratory Rate:

Infant (<1yr):	30- 60
Toddler (1-3yr):	24 -40
Preschooler(4-5yr):	22- 34
School-age(6-12yr):	18 -30
Adolescent(13-18yr):	12 -20

Normal Pulse Rate:

Infant:	100-160
Toddler:	90-150
Preschooler:	80-140
School-age:	70-120
Adolescent:	60-100
Pulses slower in sleeping child / athlete	

Lower Limit of Normal Systolic BP:

Infant:	>60 (or strong pulses)
Toddler:	>70 (or strong pulses)
Preschooler:	>75
School-age:	>80
Adolescent:	>90
Estimated min.SBP >70 + (2 x age in yr)	

This reference card should not be considered to 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

Dry, Warm, Position, Tactile Stimulation.
Suction Mouth then Nose.
Call for ALS back-up. Administer O2 as needed.

Apnea/Gasping, HR <100 or central cyanosis

Ventilate with BVM @ 40-60/min

HR<60 after 30 sec. BVM

Chest Compressions @ 120/min - 3:1
1/3 to 1/2 chest depth
2 thumb encircle chest or 2 fingers

ALS available & HR <60

Intubate
Epinephrine
0.01-0.03mg/kg
IV/IO/ET
1:10,000
q 3-5 min

CPR Notes:

- Start CPR for arrest or HR<60 with poor perfusion.
- AEDs with pediatric capabilities are preferred for patients < 25kg or 55lb (approximately age 8 yrs. of age).
- Do not pause CPR for more than 10 sec. for pulse checks, intubation, patient transfer or other reasons. Give medications during CPR whenever possible.

ALS Guidelines

Asystole or PEA

Secure airway & ventilate with oxygen
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

Secure airway & ventilate with oxygen.
Intubate if decreased consciousness & needed to maintain airway.
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
0.1 mg/kg 1:1000 ET
Continue Epinephrine q 3-5 min, same dose
Defibrillate 4j / kg & resume CPR immed.
Amiodarone 5mg/kg IV/IO (preferred) or
Lidocaine 1mg / kg IV/ IO/ ET or
If torsades de pointes or hypomagnesemia -
Magnesium 25-50mg/kg IV/ IO
Defibrillate 4j / kg q 2 min as needed

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

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

Respiratory / Cardiac Arrest Treatment

	Infant	Child	Adol/Adult
Ventilation only	20/min	20/min	12/min
Compression Method	<u>Encircle</u> or 2 fingers	1 hand or 2 hand	2 hand
Compression Depth	1/3-1/2 chest diameter		
Compression Rate	100/min	100/min	100/min
Ratio-2 provider	15:2	15:2	30:2
Push hard & fast and allow full chest recoil!			

- Do not synchronize ventilations/compressions once the patient is intubated.
- Do 2 minutes CPR starting with compressions after defibrillation before pulse/rhythm checks are done.
- Adolescent/Adult protocols apply to patients with readily observable signs of puberty such as breast development obvious through clothing, facial hair, acne, adult appearance/size, or visible axillary hair.

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