

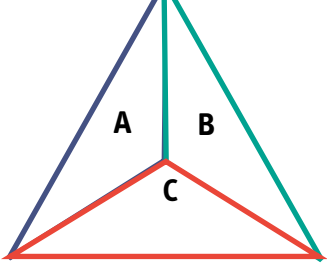
PEDIATRIC ASSESSMENT



General Impression (First view of patient)

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

Work of Breathing
(Visible movement / Respiratory Effort)



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.

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.

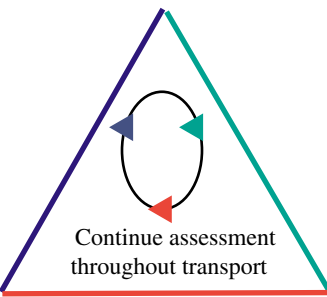
Decision/Action Points:

- 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.
- All findings normal (non-urgent) – proceed to Initial Assessment.

Initial Assessment (Primary Survey)

Airway & Appearance
(Open/Clear – Mental Status)

Breathing
(Effort / Sounds / Rate / Central Color)



Abnormal: Obstruction to airflow. Gurgling, stridor or noisy breathing. Verbal, Pain, or Unresponsive on AVPU scale.
Normal: Clear and maintainable. Alert on AVPU scale.

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.

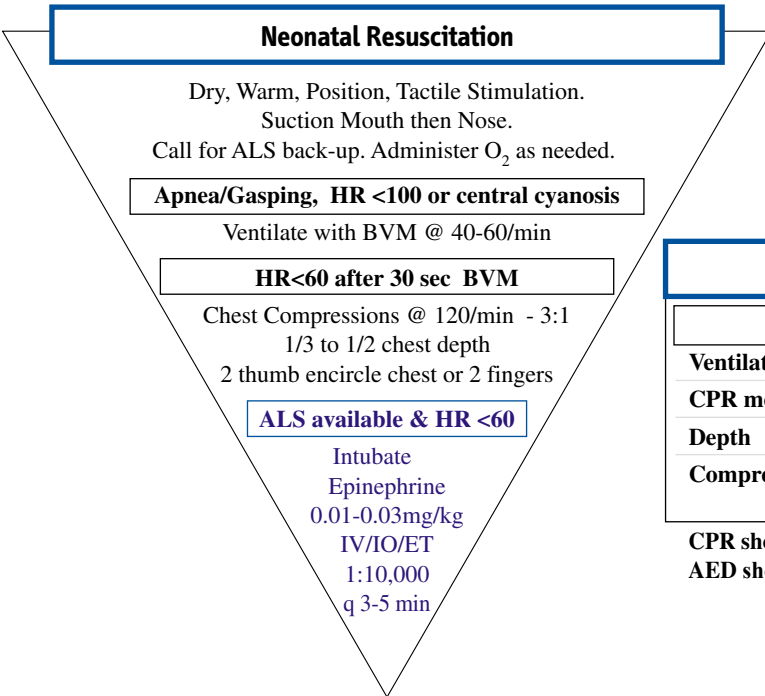
Decision/ Action Points:

- Any abnormal finding (C, U, or P) – Check for causes such as diabetes, poisoning, trauma, seizure, etc. Assist patient with prescribed bronchodilators or epinephrine auto-injector, if appropriate.
- All findings on assessment of child normal (S) – Continue assessment, detailed history & treatment.

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)

Pediatric CUPS (with examples)	
Critical	Absent airway, breathing or circulation (cardiac or respiratory arrest or severe traumatic injury)
Unstable	Compromised airway, breathing or circulation (unresponsive, respiratory distress, active bleeding, shock, active seizure, significant injury, shock, near-drowning, etc.)
Potentially Unstable	Normal airway, breathing & circulation but significant mechanism of injury or illness (post-seizure, minor fractures, infant < 3mo with fever, etc.)
Stable	Normal airway, breathing & circulation No significant mechanism of injury or illness (small lacerations or abrasions, infant ≥3mo with fever)

Glasgow Coma Score		
Infants	Children /Adults	
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 / Cardiac Arrest Treatment			
	Infant <1yr	Child 1-8yr	Teen 9-18yr
Ventilation only	12-20 bpm	12-20 bpm	10-12 bpm
CPR method	2 fingers	1 hand	2 hand
Depth	1/3-1/2 of the depth of the chest		
Compression Rate	100/min	100/min	100/min
Ratio	30:2/15:2	30:2/15:2	30:2

CPR should be started for HR<60.

AED should be used on patients ≥1-8 yr of age (with energy reducer).

APGAR Score			
	0 pts	1 pt	2 pts
Pulse	Absent	<100	≥100
Resp	Absent	Slow/Irregular	Good
Tone	Limp	Some flexion	Active motion
Reflex	None	Grimace	Cough/Sneeze
Color	Blue	Pink Body Blue Limbs	All Pink

ALS Guidelines		
Asystole or PEA Assess airway & start CPR Intubate & ventilate with oxygen 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 Consider hi dose 0.1 mg/kg 1:1000 IV/IO/ET Consider possibility of hypoxia, hypovolemia, hypothermia, hyper/hypokalemia, tamponade, tension pneumothorax, toxins/poisons/drugs or thromboembolism & treat if present.	Bradycardia Assess airway & give oxygen Intubate if decreased consciousness Start CPR if HR<60. 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 / ET minimum dose 0.1 mg maximum dose 0.5 mg child; 1.0 mg teen	VF or pulseless VT Assess airway & start CPR - Defibrillate at 2j /kg Start CPR, intubate, ventilate with O ₂ Epinephrine: 0.01 mg/kg 1:10,000 IV/ IO 0.1 mg/kg 1:1000 ET Defibrillate 4j / kg Amiodarone 5mg/kg IV/IO or Lidocaine 1mg / kg IV/ IO/ ET or Magnesium 25-50mg/kg IV/ IO (for torsades de pointes or hypomagnesemia) Defibrillate 4j / kg

This reference card should not be considered to replace or supercede regional prehospital medical treatment protocols.