



# PEDIATRIC ASSESSMENT

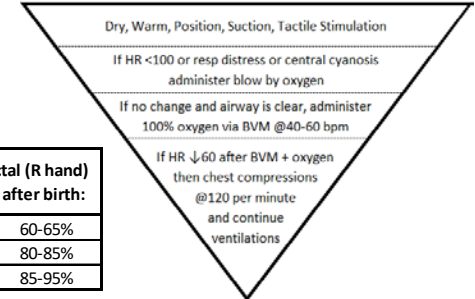


## Normal Pediatric Vital Signs

Age	Weight (kg)	Heart Rate Awake	Heart Rate Sleeping	Resp Rate	SpO <sub>2</sub>	Systolic BP (mmHg)	Capillary Refill Time
0-1 mo	3-5 kg	85-205	80-160	30-60	94-99%	60	<3 secs.
1-3 mo	3-5 kg	85-205	80-160	30-60	94-99%	70	<3 secs.
3 mo - 1 yr	6-10 kg	100-190	75-160	30-60	94-99%	70	<3 secs.
Toddler 1-2 yr	10-14 kg	100-190	75-160	24-40	94-99%	70 + (Age in years x2)	<3 secs.
Toddler 3-4 yr	14-18 kg	60-140	60-90	24-40	94-99%	70 + (Age in years x2)	<3 secs.
Preschooler	19-23 kg	60-140	60-90	22-34	94-99%	70 + (Age in years x2)	<3 secs.
School Age	24-39 kg	60-140	60-90	18-30	94-99%	70 + (Age in years x2)	<3 secs.
Adolescent (10+ yr)	30+ kg	60-100	50-90	12-16	94-99%	90	<3 secs.

Glasgow Coma Scale			
Adult GCS		Pediatric GCS	
Eye Opening (4)			
Spontaneous	4	Spontaneous	4
To Speech	3	To Speech	3
To Pain	2	To Pain	2
None	1	None	1
Best Motor Response (6)			
Obeys Commands	6	Spontaneous Movement	6
Localizes Pain	5	Withdraws to Touch	5
Withdraws from Pain	4	Withdraws from Pain	4
Abnormal Flexion	3	Abnormal Flexion	3
Abnormal Extension	2	Abnormal Extension	2
None	1	None	1
Best Verbal Response (5)			
Oriented	5	Coos, Babbles	5
Confused	4	Irritable Cry	4
Inappropriate	3	Cries to Pain	3
Incomprehensible	2	Moans to pain	2
None	1	None	1

## Newborn Resuscitation



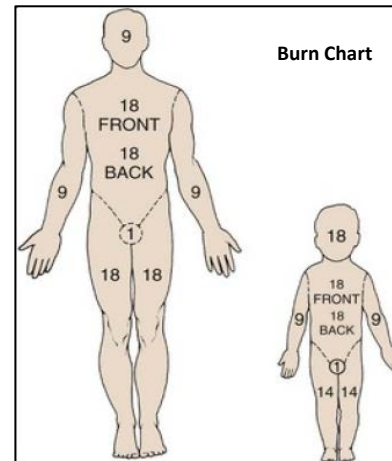
Target Preductal (R hand) O2 saturation after birth:	
1 min	60-65%
5 min	80-85%
10 min	85-95%

APGAR Scoring Chart				
SIGN	2	1	0	
APPEARANCE	All pink	Blue extremities, pink torso	Blue	
PULSE	≥100	<100	Absent	
GRIMACE	Strong grimace	Some facial grimace	Absent	
ACTIVITY	Good extremity flexion	Some extremity flexion	Limp	
RESPIRATORY EFFORT	Strong cry	Weak cry	Absent	



Croup Severity Score		
Level of consciousness	Normal (including sleep)	0
	Disoriented	5
Cyanosis	None	0
	Cyanosis at agitation	4
	Cyanosis at rest	5
Stridor	None	0
	When agitated	1
	At rest	2
Air Entry	Normal	0
	Decreased	1
	Markedly decreased	2
Retraction	None	0
	Mild	1
	Moderate	2
	Severe	3

AVPU Response	Infant	Child
<b>A = Alert</b>	Curious Recognizes Parents	Alert Aware of surroundings
<b>V = Responds to Voice</b>	Irritable, Cries	Opens Eyes
<b>P = Responds to Pain</b>	Cries to Pain	Withdraws
<b>U = Unresponsive</b>	No Response	No Response



FLACC Pain Scale			
Categories	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested, sad, appears worried	Frequent to constant quivering chin, clenched jaw, distressed looking face, expression of fright/panic
Legs	Normal position or relaxed, usual tone & motion to limbs	Uneasy, restless, tense, occasional tremors	Kicking, or legs drawn up, marked increase in spasticity, constant tremors, jerking
Activity	Lying quietly, normal position, moves easily, regular, rhythmic respirations	Squirming, shifting back and forth, tense, tense/guarded movements, mildly agitated, shallow/splinting respirations, intermittent sighs	Arched, rigid or jerking, severe agitation, head banging, shivering, breath holding, gasping, severe splinting
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint, occasional verbal outbursts, constant grunting	Crying steadily, screams or sobs, frequent complaints, repeated grunting
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort, pushing caregiver away, resisting care or comfort measures

Bronchiolitis Severity Score	Normal (0)	Mild (1)	Moderate (2)	Severe (3)
Respiratory Rate	< 40	40-50	50-60	> 60
SaO <sub>2</sub> % RA	≥ 97	96-94	93-90	< 90
General Appearance Calm/Console	Calm	+ Irritable Easy to console	++ Irritable Difficult to console	+++ Irritable Unable to console
Retractions (SS, IC, SC) Nasal Flaring (NF)	None	Subcostal	Intercostal	Supraclavicular, Suprasternal, or Paradoxical
Auscultation	Clear	Scattered end expiratory wheeze or crackles	Diffuse expiratory wheeze or crackles	Ins/Exp wheeze or crackles; poor air movement; grunting

Total score ≥10 is considered severe