



Office of Emergency Medical Services

Pediatric Assessment Guide

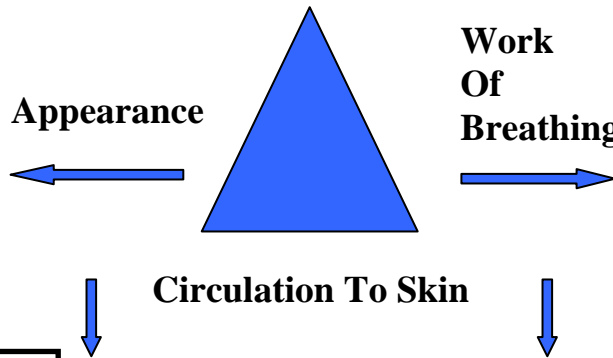
Pediatric Assessment Triangle



Assessment Points: Responsiveness, Muscle Tone, Body position, GCS, AVPU.

Abnormal: Weak cry, Decreased responsiveness to parent Floppy, not moving or stiff

Normal: Normal cry /speech. Responsive to parent. Good muscle tone. Moves extremities well.



Assessment Points: Respiratory Effort, Sounds, Rate, Central Color.

Abnormal: Retractions, nasal flaring, stridor, wheezes, grunting, or gasping. Abnormal Respiratory rate outside normal range. Central cyanosis (tongue, nailbeds).

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

Glasgow Coma Scale			
Infant	Eye Opening	Child	Adult
4	Spontaneously	4	4
3	To Speech	3	3
2	To Pain	2	2
1	No Response	1	1
Best Verbal Response			
5	Coos, Babbles	Oriented	5
4	Irritable Cries	Confused	4
3	Cries to pain	Inappropriate Words	3
2	Moans, grunts	Incomprehensible	2
1	No Response	No response	1
Best Motor Response			
6	Spontaneous	Obeys Commands	6
5	Localizes Pain		5
4	Withdraws from Pain		4
3	Flexion (decorticate)		3
2	Extension (decerebrate)		2
1	No Response		1

Assessment Points: Obvious Bleeding, Pulse Rate & Strength, Extremity Perfusion, Paleness, Capillary refill time.

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

Normal: No significant bleeding. Capillary refill ≤ 2 sec. Strong peripheral and central pulses with regular rhythm.

Child Abuse and Neglect

1. Injuries at variance with history given.
2. Condition resulting in maltreatment, malnutrition, sexual molestation or exploitation.
4. Deprivation of necessities
5. Emotional maltreatment or cruel punishment
6. Child Neglect.

DCF HotLine
1-800-842-2288

Normal Respiratory Rates	
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 Rates	
Infant (<1yr)	100-160
Toddler (1-3yr)	90-150
Preschooler (4-5yr)	80-140
School age (6-12yr)	70-120
Adolescent (13-18yr)	60-100

Low Limit of Normal Systolic BP	
Infant (<1yr)	>60, OR Strong Pulses
Toddler (1-3yr)	>70, OR Strong Pulses
Preschooler (4-5yr)	>75
School age (6-12yr)	>80
Adolescent (13-18yr)	>90
Estimate = 70 + (2 X age in yrs.)	

Newborn

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

IF: Apnea/Gasping, <HR 100 or Central

Ventilate with BVM @ 40-60/min

IF: HR< 60 after 30 seconds

Chest Compressions @ 120/min – 3:1 ratio
1/3 to 1/2 chest depth
2 thumbs encircling chest or 2 fingers

APGAR Score				
		0 pts	1 pt	2 pts
A	Activity	Absent	Some Flexation	Active Movement
P	Pulse	Absent	<100	>100
G	Grimace	No Response	Grimace	Cough or Sneeze
A	Appearance	Blue, Pale	Body Pink,	All Pink
R	Resp.	Absent	Slow, Irregular	Good, Crying

Take Score at 1 minute and 5 minutes post birth.
Continue every 5 minutes if Newborn is unstable.

Ct. Poison Control
1-800-222-1222

LCD CMED

CHH – ED
860-496-6650

Winsted ED
860-738-6600

Always Reassess The Ill Or Injured Child!

All EMS Providers are Mandated Reporters of Child Abuse