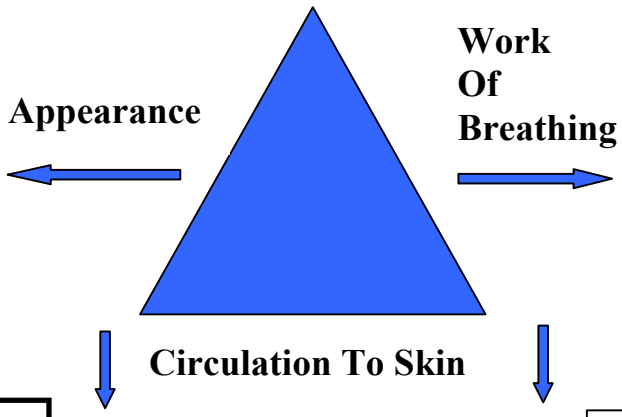
Office of Emergency Medical Services
Pediatric Assessment Guide
Pediatric Assessment Triangle

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

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.



Assessment Points: Visible movement, Respiratory 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.

Assessment Points: Color, Obvious Bleeding, Pulse Rate & Strength, Extremity Color & Temp, Capillary Refill.
Abnormal: Cyanosis, mottling, paleness, pallor or obvious significant bleeding. Absent or weak peripheral or central pulses; Pulse or systolic BP outside normal range; Capillary refill > 2 sec with other abnormal findings.
Normal: Color appears normal for racial group of child. No significant bleeding. Capillary refill at palms, soles, forehead, or central body ≤ 2 sec. Strong peripheral and central pulses with regular rhythm.

Glasgow Coma Scale

Infant	Eye Opening	Child Adult
4	Spontaneously	4
3	To Speech	3
2	To Pain	2
1	No Response	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

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

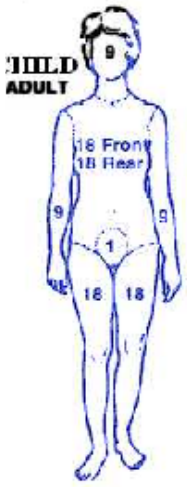
Infant (<1yr)	100-160
Toddler (1-3yr)	90-150
Preschooler (4-5yr)	80-140
School age (6-12yr)	70-120
Adolescent (13-18yr)	60-100

Lower 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.)

Burns



The patients palm is equal to **1%** of their Body Surface Area.

Remember To Constantly Reassess The Ill Or Injured Child!

Newborn Resuscitation

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 Cyanosis

Ventilate with BVM @ 40-60/min

IF: HR< 60 after 30 seconds BVM

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
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

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

This reference card should not be considered to replace or supercede regional prehospital medical treatment protocols. 11/22/00
Supported by project grant MCH#5 H15 MC 00073-05 from the Emergency Medical Services for Children program, HRSA, USDHHS, and NHTSA.