



PEDIATRIC SKILLS CHECKLIST

NAME: _____ DATE: _____

YEARS OF EXPERIENCE: _____

PLEASE INDICATE YOUR LEVEL OF EXPERIENCE

1. THEORY, NO PRACTICE - DIDACTIC INSTRUCTION ONLY, NO HANDS ON EXPERIENCE
2. LIMITED EXPERIENCE - KNOWS PROCEDURE/HAS USED EQUIPMENT, BUT HAS DONE SO INFREQUENTLY OR NOT WITHIN THE LAST SIX MONTHS.
3. MODERATE EXPERIENCE. - ABLE TO DEMONSTRATE EQUIPMENT/PROCEDURE, PERFORMS THE TASK/SKILL INDEPENDENTLY WITH ONLY RESOURCE ASSISTANCE NEEDED
4. PROFICIENT/COMPETENT - ABLE TO DEMONSTRATE/PERFORM THE TASK/SKILL PROFICIENTLY WITHOUT ANY ASSISTANCE AND CAN INSTRUCT/TEACH

A. CARDIOVASCULAR

- | | 1 | 2 | 3 | 4 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ASSESSMENT: | | | | |
| A. AUSCULTATION (RATE, RHYTHM, VOLUME) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. BLOOD PRESSURE/NON-INVASIVE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. HEART SOUNDS/MURMURS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. PERFUSION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. INTERPRETATION OF LAB RESULTS: | | | | |
| A. ARTERIAL BLOOD GASES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. HEMOGLOBIN & HEMATOCRIT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. EQUIPMENT & PROCEDURES: | | | | |
| A. BASIC EKG INTERPRETATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. NON-INVASIVE CARDIAC MONITORING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. CARE OF THE CHILD WITH: | | | | |
| A. BACTERIAL ENDOCARDITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. CARDIAC ARREST | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. CARDIOMYOPATHY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. CONGENITAL HEART DEFECTS/DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. CONGESTIVE HEART FAILURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. MYOCARDITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. PERICARDITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. POST CARDIAC CATH | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. POST CARDIAC SURGERY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. RHEUMATIC FEVER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. SHOCK | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. MEDICATION - DIGOXIN (LANOXIN) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

B. PULMONARY

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ASSESSMENT: | | | | |
| A. BREATH SOUNDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. RATE AND WORK OF BREATHING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. EQUIPMENT & PROCEDURES: | | | | |
| A. AIRWAY MANAGEMENT DEVICES/SUCTIONING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1) BULB SYRINGE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) NASAL AIRWAY/SUCTIONING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) ORAL AIRWAY/SUCTIONING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | 1 | 2 | 3 | 4 |
|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 4) TRACHEOSTOMY/SUCTIONING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. APNEA MONITOR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. CHEST PHYSIOTHERAPY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. CHEST TUBES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. END TIDAL CO2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. OXIMETER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. OXYGEN THERAPY DELIVERY SYSTEMS | | | | |
| 1) FACE MASK | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) HOOD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) ISOLETTE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) NASAL CANNULA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) TENT | | | | |
| 6) TRACH COLLAR | | | | |
| H. WATER SEAL DRAINAGE SYSTEM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CARE OF THE CHILD WITH: | | | | |
| A. ASTHMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. BRONCHIOLITIS (RSV) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. BRONCHOPULMONARY DYSPLASIA (BPD) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. CYSTIC FIBROSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. EPIGLOTTITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. PERTUSSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. LTB/CROUP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. PNEUMONIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. TONSILLITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. TUBERCULOSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. MEDICATIONS: | | | | |
| A. ALUPENT (MERAPROTERANOL) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. AMINOPHYLLINE (THEOPHYLLINE) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. ISUPREL (ISOPROTERENOL) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. VENTOLIN (ALBUTEROL) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

C. NEUROLOGICAL/ORTHOPEDICS

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ASSESSMENT - LEVEL OF CONSCIOUSNESS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. EQUIPMENT & PROCEDURES: | | | | |

NAME: _____

- | | 1 | 2 | 3 | 4 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| A. APPLICATION OF SPLINTS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ASSIST WITH LUMBAR PUNCTURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. CAST | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. ICP MONITORING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. PINNED FRACTURES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. TRACTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CARE OF THE CHILD WITH: | | | | |
| A. BATTERED CHILD SYNDROME | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. CLOSED HEAD TRAUMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. CLUBFOOT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. ENCEPHALITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. FEBRILE SEIZURES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. MENINGITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. MULTIPLE SCLEROSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. MULTIPLE TRAUMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. NEAR DROWNING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. NEUROMUSCULAR DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. OSTEOGENIC SARCOMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. OSTEOMYELITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| M. SPINAL CORD INJURY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. MEDICATIONS: | | | | |
| A. CLONOPIN (CLONAZAPAM) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. CORTICOSTEROIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DILANTIN (PHENYTOIN) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. PHENOBARBITAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. TEGRETOL (CARBAMAZEPINE) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. VALIUM (DIAZEPAM) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. GASTROINTESTINAL | | | | |
| 1. ASSESSMENT: | | | | |
| A. ABDOMINAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. NUTRITIONAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. INTERPRETATION OF LAB RESULTS - SERUM ELECTROLYTES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. EQUIPMENT & PROCEDURES: | | | | |
| A. FEEDINGS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1) BOTTLE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) BREAST | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) CENTRAL HYPERALIMENTATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) GAVAGE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) PERIPHERAL HYPERALIMENTATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. GASTROSTOMY/BUTTON | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. ITUBES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. JEJUNAL FEEDING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. NG AND SUMP TUBES TO SUCTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. PENROSE DRAINS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. PLACEMENT OF NASO/OROGASTRIC TUBE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. WOUND IRRIGATION/DRESSING CHANGE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. CARE OF THE CHILD WITH: | | | | |
| A. ANAL FISSURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. CLEFT LIP/PALATE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. COLOSTOMY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | 1 | 2 | 3 | 4 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| D. DIAPHRAGMATIC HERNIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. FAILURE TO THRIVE (FTT) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. GASTROENTERITIS/DEHYDRATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. GE REFLUX | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. GI BLEEDING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. ILEOSTOMY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. INTESTINAL PARASITES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. NECROTIZING ENTEROCOLITIS (NEC) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. PYLORIC STENOSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| M. SURGICAL ABDOMEN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| N. ULCERATIVE COLITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. RENAL/GENITOURINARY | | | | |
| 1. ASSESSMENT - FLUID BALANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. INTERPRETATION OF LAB RESULTS: | | | | |
| A. BUN & CREATININE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. URINALYSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. EQUIPMENT & PROCEDURES: | | | | |
| A. ASSIST WITH SUPRAPUBIC TAP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. CATHETER INSERTION: | | | | |
| 1) CATHETER CARE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) FEMALE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) INDWELLING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) MALE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) STRAIGHT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. COLLECTION OF URINE SPECIMEN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. CARE OF THE CHILD WITH: | | | | |
| A. CIRCUMCISION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. GLOMERULARNEPHRITIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. HEMODIALYSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. HEMOLYTIC UREMIC SYNDROME (HUS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. HYPOSPADIAS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. ILEAL CONDUIT URETERAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. INFANTILE POLYCYSTIC DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. KIDNEY TRANSPLANT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. NEPHROTIC SYNDROME | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. PERITONEAL DIALYSIS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. RENAL FAILURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. URINARY TRACT INFECTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| M. WILM'S TUMOR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. ENDOCRINE/METABOLIC | | | | |
| 1. ASSESSMENT: | | | | |
| 2. INTERPRETATION OF LAB RESULTS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A. BLOOD GLUCOSE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. THYROID STUDIES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. EQUIPMENT & PROCEDURES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A. BLOOD GLUCOSE TESTING:
Type: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. CARE OF THE CHILD WITH: | | | | |
| A. ADRENAL DISORDERS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. CUSHING'S SYNDROME | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. JUVENILE DIABETES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. PITUITARY DISORDERS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

NAME: _____

- E. THYROID MALFUNCTION 1 2 3 4
5. MEDICATIONS:
- A. GROWTH HORMONE 1 2 3 4
- B. INSULIN 1 2 3 4
- C. THYROID 1 2 3 4

G. HEMATOLOGY/ONCOLOGY

1. ASSESSMENT OF NUTRITIONAL STATUS 1 2 3 4
2. INTERPRETATION OF LAB RESULTS:
- A. BLOOD CHEMISTRY 1 2 3 4
- B. BLOOD COUNTS 1 2 3 4
3. EQUIPMENT & PROCEDURES - REVERSE ISOLATION 1 2 3 4
4. CARE OF THE CHILD WITH:
- A. ANEMIA 1 2 3 4
- B. BONE MARROW TRANSPLANT 1 2 3 4
- C. DEPRESSED IMMUNE SYSTEM 1 2 3 4
- D. DISSEMINATED INTRAVASCULAR COAGULATION (DIC) 1 2 3 4
- E. HEMOPHILIA 1 2 3 4
- F. HODGKIN'S DISEASE 1 2 3 4
- G. INFECTIOUS MONONUCLEOSIS 1 2 3 4
- H. LEUKEMIA 1 2 3 4
- I. MALIGNANT TUMORS 1 2 3 4
- J. SICKLE CELL ANEMIA 1 2 3 4
- K. SPLEEN TRAUMA/SPLENECTOMY 1 2 3 4
5. MEDICATIONS:
- A. CHEMOTHERAPY CERTIFICATION?
 YES NO
- B. PREDNISONE 1 2 3 4

H. MEDICATION ADMINISTRATION FOR CHILDREN

1. CALCULATION OF PEDIATRIC DOSES 1 2 3 4
2. EYE/EAR INSTALLATIONS 1 2 3 4
3. KNOWLEDGE OF EMERGENCY DRUGS 1 2 3 4
4. KNOWLEDGE OF ROUTINE PEDIATRIC DRUGS 1 2 3 4
5. METERED DOSE INHALER 1 2 3 4

I. PHLEBOTOMY/IV THERAPY

1. EQUIPMENT & PROCEDURES 1 2 3 4
- A. ADMINISTRATION OF BLOOD/BLOOD PRODUCTS
- 1) CRYOPRECIPITATE 1 2 3 4
- 2) PACKED RED BLOOD CELLS 1 2 3 4
- 3) WHOLE BLOOD 1 2 3 4
- B. BLOOD FROM CENTRAL LINE 1 2 3 4
- C. DRAWING VENOUS BLOOD 1 2 3 4
- D. STARTING IVs:
- 1) ANGIOCATH 1 2 3 4
- 2) BUTTERFLY 1 2 3 4
- 3) HEPARIN LOCK 1 2 3 4
2. CARE OF THE CHILD WITH:
- A. CENTRAL LINE/CATHETER/DRESSING: 1 2 3 4

- 1) BROVIAC 1 2 3 4
- 2) GROSHONG 1 2 3 4
- 3) HICKMAN 1 2 3 4
- 4) PORTACATH 1 2 3 4
- 5) QUINTON 1 2 3 4
- B. CUTDOWN LINE/DRESSING 1 2 3 4
- C. PERIPHERAL LINE/DRESSING 1 2 3 4

J. INFECTIOUS DISEASES

1. INTERPRETATION OF LAB RESULTS - BLOOD COUNT 1 2 3 4
2. EQUIPMENT & PROCEDURES
- A. FEVER MANAGEMENT 1 2 3 4
- B. ISOLATION 1 2 3 4
3. CARE OF THE CHILD WITH:
- A. AIDS 1 2 3 4
- B. COMMON CHILDHOOD - COMMUNICABLE DISEASES 1 2 3 4
- C. CYTOMEGALO VIRUS (CMV) 1 2 3 4
- D. HEPATITIS 1 2 3 4
- E. KAWASAKI DISEASE 1 2 3 4
- F. LYME DISEASE 1 2 3 4

K. MISCELLANEOUS

1. ASSESSMENT:
- A. NORMAL GROWTH AND DEVELOPMENT 1 2 3 4
- B. NORMAL LABORATORY VALUES 1 2 3 4
- C. RECOGNIZE SIGNS OF ABUSE OR NEGLECT 1 2 3 4
2. MEDICATION - IMMUNIZATION SCHEDULE 1 2 3 4
3. CARE OF THE CHILD WITH:
- A. ANOREXIA/BULIMIA 1 2 3 4
- B. CRANIOFACIAL RECONSTRUCTION 1 2 3 4
- C. DEPRESSION 1 2 3 4
- D. ENT SURGERY 1 2 3 4
- E. EYE SURGERY 1 2 3 4
- F. INGESTION OF FOREIGN BODY 1 2 3 4
- G. INGESTION OF POISON OR TOXINS 1 2 3 4
- H. PLASTIC SURGERY 1 2 3 4
- I. SUICIDAL THREATS/ACTIONS 1 2 3 4

L. WOUND MANAGEMENT

1. ASSESSMENT:
- A. SKIN FOR IMPENDING BREAKDOWN 1 2 3 4
- B. STASIS ULCERS 1 2 3 4
- C. SURGICAL WOUND HEALING 1 2 3 4
2. EQUIPMENT & PROCEDURES:
- A. 1ST DEGREE BURNS (THROUGHOUT BODY) 1 2 3 4
- B. 2ND DEGREE BURNS 1 2 3 4
- C. 3RD DEGREE BURNS 1 2 3 4
- D. PRESSURE SORES 1 2 3 4
- E. STAGED DECUBITUS ULCERS 1 2 3 4
- F. STERILE DRESSING CHANGES 1 2 3 4

NAME: _____

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | 1 | 2 | 3 | 4 |
| G. SURGICAL WOUNDS WITH DRAIN(S) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. TRAUMATIC WOUND CARE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. USE OF AIR FLUIDIZED, LOW AIRLOSS BEDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. WOUND CARE/IRRIGATIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| M. PAIN MANAGEMENT | 1 | 2 | 3 | 4 |
| 1. ASSESSMENT OF PAIN LEVEL/TOLERANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. CARE OF THE CHILD WITH: | | | | |
| A. EPIDURAL ANESTHESIA/ANALGESIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. IV CONSCIOUS SEDATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. NARCOTIC ANALGESIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**MY EXPERIENCE IS PRIMARILY IN:
(PLEASE INDICATE NUMBER OF YEARS.)**

CERTIFICATION:	EXP DATE:	CERTIFICATION:	EXP DATE:
<input type="checkbox"/> BCLS		<input type="checkbox"/> OTHER	
<input type="checkbox"/> NRP		<input type="checkbox"/> OTHER	
<input type="checkbox"/> PALS		<input type="checkbox"/> OTHER	
<input type="checkbox"/> OTHER		<input type="checkbox"/> OTHER	

- MEDICAL ____ YEAR(S)
- ONCOLOGY ____ YEAR(S)
- SURGICAL ____ YEAR(S)
- NEUROLOGY ____ YEAR(S)
- TELEMETRY ____ YEAR(S)
- PSYCHIATRY ____ YEAR(S)
- ORTHOPEDICS ____ YEAR(S)
- REHABILITATION ____ YEAR(S)
- OTHER _____ (TYPE) ____ YEAR(S)

AGE SPECIFIC PRACTICE CRITERIA:

PLEASE CHECK THE BOXES BELOW FOR EACH AGE GROUP FOR WHICH YOU HAVE EXPERTISE IN PROVIDING AGE-APPROPRIATE NURSING CARE.

A. NEWBORN/NEONATE (BIRTH - 30 DAYS)	D. PRESCHOOLER (3 - 5 YEARS)	G. YOUNG ADULTS (18 - 39 YEARS)
B. INFANT (30 DAYS - 1 YEAR)	E. SCHOOL AGE CHILDREN (5 - 12 YEARS)	H. MIDDLE ADULTS (39 - 64 YEARS)
C. TODDLER (1 - 3 YEARS)	F. ADOLESCENTS (12 - 18 YEARS)	I. OLDER ADULTS (64+)

ABLE TO ADAPT CARE TO INCORPORATE NORMAL GROWTH AND DEVELOPMENT.

- | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| A | B | C | D | E | F | G | H | I |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

ABLE TO ADAPT METHOD AND TERMINOLOGY OF PATIENT INSTRUCTIONS TO THEIR AGE, COMPREHENSION AND MATURITY LEVEL.

- | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

CAN ENSURE A SAFE ENVIRONMENT REFLECTING SPECIFIC NEEDS OF VARIOUS AGE GROUPS.

- | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

THE INFORMATION I HAVE GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE AS NEEDED STAFFING TO RELEASE THIS PEDIATRIC SKILLS CHECKLIST TO CLIENT FACILITIES OF AS NEEDED STAFFING IN RELATION TO CONSIDERATION OF MY EMPLOYMENT WITH THOSE FACILITIES.

SIGNATURE

DATE