

The defined age of a pediatric patient is **14 years old or less**, and unless specified otherwise, pediatric protocols should be used to treat these patients. Note: An infant is considered to be < 1 year old. A child is considered to be ≥ 1 year old. Specified ages for transport or treatment other than 14 include:

<p>TRANSPORT</p> <p>5150 Psych Evaluation (page 108):</p> <p>→ Children (≤ 11 y.o.) – Children’s Hospital</p> <p>→ Adolescents (≥ 12 y.o. & ≤ 17 y.o.) – Willow Rock</p> <p>Trauma Destination (page 25):</p> <p>→ ≤ 14 y.o. – Children’s Hospital</p> <p>→ ≥ 15 y.o. – Closest Adult Trauma Center</p> <p>Sexual Assault (page 3):</p> <p>→ Children (≤ 14 y.o.) – Children’s Hospital</p> <p>→ All Others (≥ 15 y.o.) – Highland, ValleyCare, or Washington</p>	<p>TREATMENT</p> <p>Advanced Airway Management (page 116):</p> <p>→ ≤ 12 y.o. - preferred airway is OPA/NPA and BVM</p> <p>CPAP (page 123):</p> <p>→ < 8 y.o. – Absolute Contraindication</p> <p>IO (page 132 adult and page 133 pediatric):</p> <p>→ ≥ 8 y.o. and ≥ 40 kg – Use EZ-IO adult needle</p> <p>→ < 8 y.o. or < 40 kg – EZ-IO pediatric needle</p> <p>Refusal of Care (page 109):</p> <p>→ ≤ 17 y.o. may not refuse transport or treatment unless legally emancipated</p>
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A pediatric **length-based resuscitation tape (LBRT)** will be used to determine drug doses, fluid volumes, defibrillation settings and equipment sizes. The tape is designed to estimate a child's weight based on length (head to heel). The tape also includes information about abnormal vital signs.

PRIMARY SURVEY		SPECIAL CONSIDERATIONS
Establish level of responsiveness	▶ AVPU: A lert, V erbal, P ainful, U nresponsive	
Evaluate airway and protective airway reflexes	▶ Identify signs of airway obstruction and respiratory distress, including: → cyanosis → intercostal retractions → choking → stridor → absent breath sounds → grunting → drooling → apnea or bradypnea → nasal flaring → tachypnea	
Secure airway	▶ Open airway using jaw-thrust and chin-lift (and/or head tilt if no suspected spinal trauma). Suction as needed. Consider placement of an oral or nasal airway adjunct if the child is unconscious ▶ If cervical spine trauma is suspected, see page 141	
Consider spinal immobilization	▶ Use chest rise as an indicator of ventilation ▶ Use pulse oximetry	
Assess need for ventilatory assistance	▶ CPR as needed (see CPR page 8) ▶ Assess perfusion using the following indicators: → heart rate → mental status → skin signs → quality of pulse → capillary refill → blood pressure	
Evaluate and support circulation. Stop Hemorrhage	▶ Perform a head-to-toe assessment, including temperature ▶ Obtain a patient history ▶ Do environmental assessment, consider possibility of intentional injury	
Continue with secondary survey	▶ Perform a head-to-toe assessment, including temperature ▶ Obtain a patient history ▶ Do environmental assessment, consider possibility of intentional injury	
Determine appropriate treatment protocols	▶ Provide family psychosocial support ▶ For drugs not on the LBRT see page 62 "Pediatric Drug Chart" ▶ When starting an IV/IO/saline lock, use chlorhexidine as a skin prep ▶ Label insertion site with "PREHOSPITAL IV – DATE and TIME" ▶ Pediatric patients are subject to rapid changes in body temperature. Steps should be taken to prevent loss of or increase in body temperature ▶ Compared to the adult patient, a small amount of fluid, lost from or administered to, a pediatric patient can result in shock or pulmonary edema ▶ Scene time for treatment of pediatric patients should be kept at a minimum. Most treatment should be done en route	