



PEDIATRIC SKILLS CHECKLIST

- 1 = No Experience
- 2 = Perform infrequently (would require some supervision)
- 3 = Able to perform without any supervision

Name: _____

Date: _____

	1	2	3
Chest physiotherapy			
Assessment of breath sounds			
Pediatric head to toe assessment			
Working knowledge of pediatric normal lab values			
Working knowledge of pediatric ABG's			
Suctioning (oro-naso-pharynx)			
Pulse Oximeter			
Insertion and maintainance of IV's			
IV meds mixing and administration			
Adminstration & monitoring of blood & blood products			
Infusion pumps			
Triple lumen catheter			
TPN and intralipids			
Administration of medication:			
IM			
IV drip			
IV push			
PO			
rectal			
subq			
topical			
Calculating pediatric dosage			
O2 Therapy:			
nasal cannula			
croup tent			
O2 analyzer			
vaporizer			
ventilation with ambu bag			

	1	2	3
assist with insertion			
assist with removal			
maintenance of			
Child/Infant CPR			
Tonsillectomy			
Cleft lip/palate			
Pre/post op teaching			
Diabetic teaching			
Care of dying infant/child			
Hemovac			
Pleuravac			
NG Tube			
Feeding Tube			
Specimen collection:			
application of collection bag			
diaper aspiration			
Intake & Output			
stool			
urine			
Care of Patient with:			
Aids			
abuse			
anemia			
broncho-pulmonary dysplasia			
croup			
cystic fibrosis			
dehydration			
emphysema/asthma			

Chest tubes:			
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epiglottitis			
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PEDIATRIC SKILLS CHECKLIST

	1	2	3
fractures of extremities			
failure to thrive			
near drowning			
PDA ligation			
RDS			
pneumonia			
prematurity			
seizures			
spina bifida			
Weighing:			
infant			
toddler			
diapers			
Diabetic insulin pump			
Assessment of needs of parents			
Team leader experience			
Charting within the legal aspects of law			
Charge nurse experience			
Knowledge of Infectious Disease Precautions			

NUMBER OF YEARS EXPERIENCE:

Peds _____ Nsy _____

CERTIFICATIONS:

CPR _____ EXP DATE: _____

PALS _____ EXP DATE: _____

OTHERS _____ EXP DATE: _____

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Premier Nursing Service to release this list to its client health care facilities.

Signature Date

Authentication By Agency:

DON Signature Date