



PLEASE CHECK THE LEVEL OF PROFICIENCY FOR EACH SKILL

- 1. HIGHLY EXPERIENCED** Proficient - Performs on a daily or weekly basis
- 2. MODERATE EXPERIENCE** May need minimal resource - Performs 1-2 times/month
- 3. LIMITED EXPERIENCE** Needs review - Performs 6 times a year
- 4. NO EXPERIENCE** Observed only

NAME _____

DATE _____

MEDICATION ADMINISTRATION

	1	2	3	4
1. Unit dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Calculation of pediatric doses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Administration of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Oral meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. IM meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. IV push meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. IV drip meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Subcutaneous meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Aerosol therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV THERAPY

1. Starting IV's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Scalp veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Angiocath insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Mixing IV's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Regulating IV's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assessment of patency / site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Discontinuing peripheral IV's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Discontinuing subclavian IV's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Heparin locks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Hickman Line / broviac line care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Subclavian line care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Use of triple lumen catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Blood and blood product transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. IV hyperalimentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Central	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Peripheral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Intralipid infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Infusion pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ISOLATION TECHNIQUES AND PRECAUTIONS

1. Universal precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Familiarity with isolation techniques and procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR SYSTEM

1. Apnea monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cardiac monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Cardio-pulmonary resuscitation of infant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cardio-pulmonary resuscitation of child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Preparation of emergency drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Interpretation of EKG rhythm strips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Care of child / infant with:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. PDA ligation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Cyanotic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Acyanotic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Disseminated intravascular coagulation (DIC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Assessment of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Pulses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Perfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Heart sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Blood pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Use of doppler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Use of palpation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Non-invasive machine (dynamap)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Care of child / infant undergoing cardiac surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Interpretation of normal HCT values	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Assistance with exchange transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Parent / child teaching for congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY SYSTEM

1. Assessment of breath sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Obtaining blood gases / lab tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Heel stick (capillary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Peripheral artery line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Chest physiotherapy (CPT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Oral / pharyngeal or nasal / pharyngeal suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Care of infant / child with:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Respiratory distress syndrome (RDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Broncho pulmonary dysplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Croup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Epiglottitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Near-drowning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Complication of AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Chest tube:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Assisting with insertion and set-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Maintenance Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Tracheostomy care and suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Calculation and administration of buffer solution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ventilation and ambu bag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Use of respiratory assistance equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Oxyhood, nasal cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. O2 analyzer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Croup tent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oximeter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent / child teaching for respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL

1. Assessment of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Level of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Fontanel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Pupil size and response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Care of infant / child with:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Reye's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. V-P shunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Spina bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Measurement of head circumference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Administration of anticonvulsive medications:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. PO / IM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. IV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Assisting with lumbar puncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 6. Maintaining a neutral thermal environment
 - A. Hyper / hypothermia blanket
 - B. Use of Isolette
- 7. Parent / child teaching

IV THERAPY

- 1. Assessment of GI status:
 - A. Measurement of abdominal girth
 - B. Assessment of bowel sounds
- 2. Stool test (PH and blood)
- 3. Nasogastric and- sump tubes
- 4. Gastrostomy tube
- 5. Gavage feeding
 - A. Nasojejunal
 - B. Nasogastric
- 6. Colostomy / ileostomy care
- 7. Phototherapy treatment
- 8. Calculation of caloric intake
- 9. Calculation and measurement of dehydration
- 10. Weight on digital scales
- 11. Care of infant / child with:
 - A. Gastroschisis / omphalacele
 - B. Tracheoesophageal fistula (TEF)
 - C. Necrotizing enterocolitis
 - D. Crohn's disease
- 12. Parent / child teaching

GENITOURINARY SYSTEM

- 1. Peritoneal dialysis
- 2. Insertion and care of Foley
- 3. S & A testing
- 4. Assisting with subrapubic tap
- 5. Care of the Infant / child with:
 - A. Urethral conduit
 - B. Wilm's tumor
 - C. Disorders of external organs
- 6. Test and interpret blood glucose levels via:
 - A. Use of glucometer

ENDOCRINE SYSTEM

- 1. Interpret normal electrolyte value
- 2. Perform and interpret blood glucose levels via:
 - A. Dextrostix
 - B. Chemstrip
 - C. Glucometer
- 3. Care of infant / child with diabetes mellitus
- 4. Care of infant / child with diabetic acidoses
- 5. Infusion of insulin pump
- 6. Parent / child teaching

ORTHOPEDIC SYSTEM

- 1. Assistance with devised (splints, braces, casts) traction
- 2. Circulation checks for neurovascular assessment
- 3. Use of dioco-electric bed
- 4. Care of child with:

- A. Post-harrington rod insertion
 - B. Osteomyelitis
 - C. Juvenile rheumatoid arthritis
 - D. Fractures
- 5. care of child in stryker frame
 - 6. Parent / child teaching

INTEGUMENTARY SYSTEM

- 1. Prevention of impaired skin integrity:
 - A. Immobility, decreased perfusion
 - B. Use of specialty beds-flexicare & clinitron
- 2. Assessment of wound healing
- 3. Assessment of color change of skin:
 - A. Jaundice
 - B. Cyanosis
 - C. Mottling
 - D. Petechiae
- 4. Collection of culture specimens:
 - A. Nasopharyngeal
 - B. Urine
 - C. Stool
- 5. Sterile dressing change
- 6. care of burned infant / child
- 7. Assessment of rashes
- 8. Parent / child teaching

HEMATOLOGIC SYSTEM

- 1. Care of child with:
 - A. Leukemia
 - B. Anemia
 - C. Sickle cell disease
- 2. Administration of factor VIII infusions
- 3. Care of child post bone marrow transplant
- 4. Assist with bone marrow aspiration
- 5. Administration of chemotherapy
- 6. Parent / child teaching

OTHER

- 1. Care of child with:
 - A. Child abuse
 - B. Failure to thrive
 - C. Cleft lip and / or palate
 - D. Cancer
 - E. Eating disorder
- 2. Care of child with developmental delay:
 - A. Cognitive
 - B. Motor
- 3. Care of child post tonsillectomy
- 4. Care of dying Infant / child
- 5. Pain management

AGE OF PATIENT CARED FOR

- 1. Neo-natal (up to 1 month)
- 2. Infant (1 month to 1 year)
- 3. Pediatric (1 to 12 years)
- 4. Adolescent (12 to 18 years)
- 5. adult (18 years +)

AFFIDAVIT STATEMENT BY THE PRACTITIONER:

I, _____ hereby acknowledge that the following information attached herein is true and correct to the best of my knowledge. In addition, I hereby authorize Advanced Medical Placement, to release the skills checklist to any client institutions of Advanced Medical Placement, in relation to my employment.

Therefore, I authorize release of this checklist on this date of _____ / _____ / _____

Signature _____ Date _____