

Pediatrics / PICU Skills Checklist

Level of Proficiency:

- 1. Can function independently**
- 2. Experienced but may need review**
- 3. Limited or no experience**

By accurately filling out this checklist, you will help us match your skills and interest with available assignments. Please select the button in the column that best describes your experience level with each skill.

MEDICATION	1	2	3	RESPIRATORY PROBLEMS	1	2	3
Unit Dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obtaining Blood Gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of Subcutaneous meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heel Stick (capillary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of IV Drip meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assessment of breath sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of IV Push meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Infant/Child With:			
Administration of IM meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of Oral meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calculation of Pediatric Dosage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near SIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of incompatibilities, interactions, and side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near-Drowning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTERVENOUS THERAPY				Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arterial Blood Gases (obtain samples)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Arterial Blood Gases (Interpretation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epiglottitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVP Monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Croup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVP Dressing Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broncho-Pulmonary Dysplasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Cutdown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(BPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hanging Blood and Blood Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PRECAUTIONS			
Heparin Locks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sterile Dressing Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initiating IV Line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wound and Skin Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intracath Insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV Hyperalimentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enteric Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intralipid Infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reverse Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infusion pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Regular Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discontinuing Peripheral IV•fs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR PROBLEMS			
Discontinuing Subclavian IV•fs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Palpation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regulating IV•fs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Doppler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mixing IV•fs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment of Patency/Site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assessment of heart sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY THERAPY				Assessment of Perfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assessment of Pulses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assist with exchange Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharynx Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interpretation of EKG rhythmstrips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ventilators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Preparation of Emergency Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tracheostomy Care & Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary Resuscitation of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endotracheal Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resuscitation of Infant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ventilation with Ambu Bag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardio-Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of O ₂ Mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Nasal Cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apnea Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Croup Tent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER PROBLEMS			
Use of Oxyhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Child/Infant with:			
Breath Sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL PROBLEMS				Dying Child/Infant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment of Level of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment of Fontanel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Acidosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment of Pupils size and Response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist with Lumbar Puncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failure to Thrive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Application of Splints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cleft Palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICP Monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Juvenile Suicidal Patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Infant/Child with:				Use of Hyper/Hypothermia Blanket	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Isolette	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Febrile Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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|--------------------|--------------------------|--------------------------|--------------------------|
| Reye's Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Meningitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| V-P Shunt | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hydrocephalus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spina Bifida | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Name _____

Address _____

Date _____

Signature _____