# Recommendations for Preventive Pediatric Health Care

These recommendations represent a consensus of the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.


The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

## Appendix I

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<thead>
<tr>
<th>AGE</th>
<th>Prenatal*</th>
<th>Neonate</th>
<th>3 mos</th>
<th>6 mos</th>
<th>12 mos</th>
<th>18 mos</th>
<th>24 mos</th>
<th>36 mos</th>
<th>48 mos</th>
<th>60 mos</th>
<th>72 mos</th>
<th>96 mos</th>
<th>120 mos</th>
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### MEASUREMENTS

- **Length/Height and Weight**
- **Head Circumference**
- **Achieve the Length**
- **Body Mass Index (BMI)**
- **Blood Pressure**

### DEVELOPMENTAL/BEHAVIORAL HEALTH

- **Behavioral Screenings**
- **Action-Related Screenings**
- **Developmental Screenings**
- **Psychosocial Screenings**
- **Visual Acuity, Refractive Error, and Hearing Screenings**

### PHYSICAL EXAMINATIONS

- **Neonate Health**
- **Newborn (Within 1 Mo)**
- **Critical Congenital Heart Defects**
- **Venous Anomalies**
- **Anemia**
- **Substance Use**
- **Disorders**
- **Sexually Transmitted Infections**
- **Genitalia**

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### PROCEDURES

- **Neonate Health**
- **Newborn (Within 1 Mo)**
- **Critical Congenital Heart Defects**
- **Venous Anomalies**
- **Anemia**
- **Substance Use**
- **Disorders**
- **Sexually Transmitted Infections**
- **Genitalia**

### PEDIATRIC MEDICATIONS

- **Rash**
- **Pneumococcal Vaccine**

### KEY

- **+** = to be performed
- **-** = risk assessment to be performed with appropriate action to follow if positive
- **—** = change during which a service may be provided

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**Notes:**

1. If a child comes to care at the first time at any point on the schedule, or at any time, or is not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

2. A prenatal visit is recommended for parents who are at high risk, the first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, parental medical history, and a discussion of benefits of breastfeeding and planned method of feeding. For “The Prenatal Visit” [http://pediatrics.aappublications.org/content/81/6/1575.d](http://pediatrics.aappublications.org/content/81/6/1575.d).

3. Neonates should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).

4. Neonates should be evaluated within 1 to 3 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation of feeding and position. Breastfeeding examinations should concern normal breastfeeding evaluation, and their conduct should ensure management and instruction as recommended in “The Evaluation of the Neonate” [http://pediatrics.aappublications.org/content/93/1/154](http://pediatrics.aappublications.org/content/93/1/154).

5. Screen for Tobacco Constituent Residues (TCCR) prior to attempting the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report [http://pediatrics.aappublications.org/content/135/Supplement_1/154](http://pediatrics.aappublications.org/content/135/Supplement_1/154).

6. Screening should occur per “Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents” [http://pediatrics.aappublications.org/content/135/Supplement_1/154#s1](http://pediatrics.aappublications.org/content/135/Supplement_1/154#s1). Measurement of blood pressure in infants and children with specific risk conditions should be performed at visits before age 5 years.

7. In infants and young children, height and weight should be measured at least every 6 months.

8. A visual acuity screen is recommended at ages 4 to 6 years, as well as in cooperative 5-year-olds. Instruments-based screening may also need to assess risk at ages 2 and 5 years, in addition to the well-child at 3 through 5 years of age. See “Visual System Assessment in Infants, Children, and Young Adults by Pediatrics” [http://pediatrics.aappublications.org/content/137/Supplement_1/154](http://pediatrics.aappublications.org/content/137/Supplement_1/154) and “Precautions for the Evaluation of the Visual System by Pediatrics” [http://pediatrics.aappublications.org/content/137/Supplement_1/154](http://pediatrics.aappublications.org/content/137/Supplement_1/154).

9. Carisil-based screens were completed, with results and follow-up as appropriate. Neonates should be screened per “2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs” [http://pediatrics.aappublications.org/content/120/Supplement_1/154](http://pediatrics.aappublications.org/content/120/Supplement_1/154).

10. Visual acuity can be assessed and followed, as appropriate.

11. Screen for visual acuity by project and chart the healthy progresses in vision for ages 5 to 7 years, between 5 and 7 years, and once between 6 and 9 years. See “First Time: Hearing and Vision” [http://pediatrics.aappublications.org/content/135/Supplement_1/154](http://pediatrics.aappublications.org/content/135/Supplement_1/154).

12. Screening should occur per “Identification and Evaluation of Children With Attention Spectrum Disorders” [http://pediatrics.aappublications.org/content/135/Supplement_1/154](http://pediatrics.aappublications.org/content/135/Supplement_1/154) and “Screening for Autism Spectrum Disorders” [http://pediatrics.aappublications.org/content/135/Supplement_1/154](http://pediatrics.aappublications.org/content/135/Supplement_1/154).

13. At each visit, age-appropriate physical examination is essential, with weight and height used and corrected as needed and velocity. Use of “Screening for the Physical Examination of the Pediatric Patient” [http://pediatrics.aappublications.org/content/135/Supplement_1/154](http://pediatrics.aappublications.org/content/135/Supplement_1/154).

14. Recommended screening visit is available at [http://pediatrics.aappublications.org/content/135/Supplement_1/154](http://pediatrics.aappublications.org/content/135/Supplement_1/154).

15. Recommended screening using the National Health Examination (NEH) is available at [http://pediatrics.aappublications.org/content/135/Supplement_1/154](http://pediatrics.aappublications.org/content/135/Supplement_1/154).
Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in December 2018 and published in March 2019. For updates and a list of previous changes made, visit www.aap.org/periodicity schedule.

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

• Footnote 6 has been updated to read as follows: “Screening should occur per ‘Clinical Practice Guidelines for Screening and Management of High Blood Pressure in Children and Adolescents’ (http://pediatrics.aappublications.org/content/110/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.”

ANEMIA

• Footnote 24 has been updated to read as follows: “Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition Policy of the American Academy of Pediatrics (Iron chapter).”

LEAD

• Footnote 25 has been updated to read as follows: “For children at risk of lead exposure, see ‘Prevention of Childhood Lead Toxicity’ (http://pediatrics.aappublications.org/content/138/1/e20161943) and Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention (https://www.cdc.gov/nceh/lead/ACCLLP/Final_Document_030712.pdf).”

HRSA

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