These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care. Refer to the specific guidance by age as listed in the Bright Futures Guidelines (Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017). 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.

1. If a child comes under care for the first time at any point on the schedule, or if any items are 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, for first-time parents, and for those who request a preconception visit. See “Preconception Health and Health Care” http://pediatrics.aappublications.org/content/127/4/893.full.

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

4. Neonates should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in “Breastfeeding and the Use of Human Milk” (http://pediatrics.aappublications.org/content/120/3/451.full). Neonates discharged less than 48 hours after delivery must be evaluated within 48 to 72 hours after discharge. See “Hospital Stay for Healthy Term Newborns” http://pediatrics.aappublications.org/content/121/3/405.full.


6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.

7. A visual acuity screen is recommended at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See “Visual System Assessment in Infants, Children, and Young Adults by Pediatricians” http://pediatrics.aappublications.org/content/137/1/145.full and “Screening for Amblyopia” http://pediatrics.aappublications.org/content/137/1/155.full.

8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per “Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs” http://pediatrics.aappublications.org/content/120/4/898.full.

9. Verify results as soon as possible, and follow up, as appropriate.

10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See “The Serendity of Adolescent Hearing Screens Significantly Improved by Adding High Frequencies” http://www.prenahcom.org/1564-3931/10004-9000.html.

11. Screen with hearing screening devices from 6 to 12 months of age.


13. This statement should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See “Promoting Optimal Development: Screening for Behavioral and Emotional Problems” http://pediatrics.aappublications.org/content/137/3/550.full and “Privacy and Child Health in the United States” http://pediatrics.aappublications.org/content/117/4/801.full.


15. Recommended screening using the Patient Health Questionnaire (PHQ-2) or other tools is available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/NIH-ScreeningChart.pdf.

16. Screening should occur per “Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice” http://pediatrics.aappublications.org/content/127/1/193.

17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See “Use of Chaperones During the Physical Examination of the Pediatric Patient” http://pediatrics.aappublications.org/content/125/5/1032.full.

18. These may be modified, depending on entry point into schedule and individual need.

(continued)
DEPRESSION SCREENING

Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force (USPSTF)).

MATERNAL DEPRESSION SCREENING

Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.

Footnote 16 was added to read as follows: “Screening should occur per ‘Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice’ (http://pediatrics.aappublications.org/content/126/5/1012).”

NEWBORN BLOOD

Timing and follow-up of the newborn blood screening recommendations have been delineated.

Footnote 19 has been updated to read as follows: “Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genetics.ufl.edu/steps/genes-r-s/files/obsdorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.”

NEWBORN BILIRUBIN

Bilirubin screening for bilirubin concentration at the newborn visit has been added.

Footnote 21 has been updated to read as follows: “Confirm initial screening was accomplished, verified results, and follow up, as appropriate. See ‘Low Level Lead Exposure Harms Children: Significantly Improves by Adding High Frequencies’ (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).”

DYSLIPIDEMIA

Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

Footnote 29 has been updated to read as follows: “Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases.”

HIV

A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.

Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).

Footnote 30 has been updated to read as follows: “Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/usps/hiv.htm) once between the ages of 15 and 18, making every effort to present confidentiality of the adolescent. Those at increased risk of HIV infections, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.”

ORAL HEALTH

Assessing for a dental home has been updated to occur at the 12-month and 18-month by 6-year visit. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.

Footnote 32 has been updated to read as follows: “Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See ‘Maintaining and Improving the Oral Health of Young Children’ (http://pediatrics.aappublications.org/content/134/6/1224).”

Footnote 33 has been updated to read as follows: “Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.”

Footnote 4 has been updated to read as follows: “Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf).”

Footnote 34 has been updated to read as follows: “Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See ‘Maintaining and Improving the Oral Health of Young Children’ (http://pediatrics.aappublications.org/content/134/6/1224).”

Footnote 35 has been added to read as follows: “If primary water source is deficient in fluoride, consider oral fluoride supplementation. See ‘Fluoride Use in Caries Prevention in the Primary Care Setting’ (http://pediatrics.aappublications.org/content/134/4/924).”

CHANGES MADE IN FEBRUARY 2017

HEARING

• Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has been added to change screening once during each time period.

• Footnote 8 has been updated to read as follows: “Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per ‘Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs’ (http://pediatrics.aappublications.org/content/120/4/898.Full).”

• Footnote 9 has been added to read as follows: “Verify results as soon as possible, and follow up, as appropriate.”

• Footnote 10 has been added to read as follows: “Screen: with audiometry including 6,000 and 8,000 Hz high frequencies once between 13 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. 11. The Sensitivity of Adolescent Heart Screening Significantly Improves by Adding High Frequencies’ (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).”

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

• Footnote 13 has been added to read as follows: “This assessment should be family centered and may include an assessment of child psychological, social-emotional health, caregiver depression, and social determinants of health. See ‘Promoting Optimal Development: Screening for Behavioral and Emotional Problems’ (http://pediatrics.aappublications.org/content/135/2/384) and ‘Poverty and Child Health in the United States’ (http://pediatrics.aappublications.org/content/137/6/e20160339).

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

The header was updated to be consistent with recommendations.