Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who receive competent parenting, have no manifest or unrecognized important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP recognizes 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 PK, 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 serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.


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1. If a child comes under care for the first time at any age 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 conference. The prenatal visit should include antepartum guidelines, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of delivery, per “The Prenatal Visit” (http://pediatrics.aappublications.org/content/124/1/276).

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

4. Newborns should have a newborn 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/129/5/e827.full). Newborns discharged less than 48 hours after delivery should undergo a formal evaluation of discharge (see “Hospital-Based Screening for High-Risk Newborns” (http://pediatrics.aappublications.org/content/127/5/e445.full).


6. Screening should occur per “Clinical Practice Guidelines for Screening and Management of High Blood Pressure in Children and Adolescents” (http://pediatrics.aappublications.org/content/140/5/904). Blood pressure measurement in infants and children with specific risk conditions should be performed at 3 to 5 years of age.

7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess vision 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/e151966) and “Procedures for the Evaluation of the Visual System by Pediatricians” (http://pediatrics.aappublications.org/content/137/1/e151967). A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess vision 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/e151966) and “Procedures for the Evaluation of the Visual System by Pediatricians” (http://pediatrics.aappublications.org/content/137/1/e151967).


9. The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.


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Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in October 2019 and published in March 2020. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN OCTOBER 2019

MATERNAL DEPRESSION

• Footnote 16 has been updated to read as follows: “Screening should occur per ‘Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice’ (https://pediatrics.aappublications.org/content/143/1/e20183259).”

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

• Footnote 6 has been updated to read as follows: “Screening should occur per ‘Clinical Practice Guidance for Screening and Management of High Blood Pressure in Children and Adolescents’ (http://pediatrics.aappublications.org/content/140/3/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/138/7/e20161493) and Low Lead Level Exposure Harms Children: A Renewed Call for Primary Prevention” (https://cdc.gov/rtch/lead/ACCLPP/Final_Document_030712.pdf).”

9. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Protocol (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Universal-Screening-Protocol.aspx) as determined by The Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/newborn-screening/status) establish the criteria for and coverage of newborn screening procedures and purposes.

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

21. Confirm screening was accomplished, verify results, and follow up, as appropriate. See “Hyperbilirubinemia in the Newborn Infant ≥35 Weeks’ Gestation: An Update With Clarifications” (http://pediatrics.aappublications.org/content/124/1/18).

22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per “Endorsement of Health and Human Services Recommendation for Pulse Oximetry ‘Screening for Critical Congenital Heart Disease’” (http://pediatrics.aappublications.org/content/125/1/2).

23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://redbook.solutions.aap.org/SS/immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child’s immunizations.


25. For children at risk of lead exposure, see “Prevention of Childhood Lead Toxicity” (http://pediatrics.aappublications.org/content/138/7/e20161493) and Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention” (https://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).

26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.

27. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per “Endorsement of Health and Human Services Recommendation for Pulse Oximetry ‘Screening for Critical Congenital Heart Disease’” (http://pediatrics.aappublications.org/content/125/1/2).