

CERTIFIED SPECIALIST IN PEDIATRICS PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

<https://specialistinpeditrics.examzify.com>



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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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1. For infants taking less than how many mL of formula per day should vitamin D also be supplemented?
 - A. 500 mL
 - B. 750 mL
 - C. 1000 mL
 - D. 1500 mL
2. Peripheral parenteral nutrition is limited to what maximum osmolarity?
 - A. 500 mOsm/L
 - B. 700 mOsm/L
 - C. 900 mOsm/L
 - D. 1100 mOsm/L
3. Patients with steroid-induced hyperglycemia should avoid what type of food?
 - A. High protein foods
 - B. Concentrated sweets
 - C. High fiber foods
 - D. Low-fat foods
4. Acyanotic defects primarily affect which aspect of weight in children?
 - A. Length growth
 - B. Weight gain
 - C. Body fat percentage
 - D. Muscle mass development
5. Which behavior indicates fullness in infants aged 4 months to 6 months?
 - A. Reaches for food
 - B. Waves hands
 - C. Falls asleep
 - D. Stops sucking

6. What is the recommended ratio of medium-chain triglycerides (MCT) in nutritional supplementation for cholestasis?
- A. 1:3
 - B. 1:2
 - C. 1:1
 - D. 1:4
7. What is the caloric goal for enteral nutrition in term infants?
- A. 100-110kcal/kg
 - B. 100-120kcal/kg
 - C. 100-130kcal/kg
 - D. 90-140kcal/kg
8. In infants weighing less than 1000g, what is the limit for calcium gluconate during the first 72 hours of life?
- A. 1.0 mmol/100mL
 - B. 1.5 mmol/100mL
 - C. 2.0 mmol/100mL
 - D. 2.5 mmol/100mL
9. What is considered a preterm birth?
- A. Greater than 42 weeks
 - B. Under 37 weeks
 - C. Between 37 and 42 weeks
 - D. Exactly 40 weeks
10. What ratio is used for adding phosphorus to calcium in infants?
- A. 1:3 ratio
 - B. 1:5 ratio
 - C. 1:7 ratio
 - D. 1:9 ratio

Answers

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1. C
2. C
3. B
4. B
5. D
6. C
7. C
8. A
9. B
10. C

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Explanations

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1. For infants taking less than how many mL of formula per day should vitamin D also be supplemented?

- A. 500 mL
- B. 750 mL
- C. 1000 mL**
- D. 1500 mL

The correct answer is based on established guidelines regarding the nutritional needs of infants, particularly in relation to vitamin D supplementation. Infants who consume less than 1000 mL of formula per day are at risk of inadequate vitamin D intake because infant formula is typically fortified with this vitamin. Breast milk, while an excellent source of nutrition, generally contains insufficient levels of vitamin D. Because vitamin D is essential for bone health and development, the recommendation is that if an infant's intake of formula is below 1000 mL per day, vitamin D supplementation is necessary to help prevent deficiencies. This supplementation is particularly important to avoid conditions such as rickets, which can occur from prolonged low vitamin D levels. In contrast, higher volumes of formula intake beyond this threshold typically provide enough vitamin D, reducing the need for additional supplementation. Consequently, the value of 1000 mL serves as a critical cut-off in nutritional guidelines for pediatric care.

2. Peripheral parenteral nutrition is limited to what maximum osmolarity?

- A. 500 mOsm/L
- B. 700 mOsm/L
- C. 900 mOsm/L**
- D. 1100 mOsm/L

Peripheral parenteral nutrition (PPN) is designed to provide nutritional support through the peripheral veins, and it is important to adhere to specific osmolarity limits to prevent complications such as thrombophlebitis or vein irritation. The maximum osmolarity for PPN is generally capped at 900 mOsm/L. This limit is set because concentrations higher than this can cause significant discomfort and vascular complications as the higher osmotic pressure can damage endothelial cells of the veins and lead to inflammation. Additionally, higher osmolarity solutions can also result in difficult infusion and potential for phlebitis, making the safety profile of PPN critical especially in pediatric patients where vein integrity is vital. Therefore, maintaining an osmolarity at or below 900 mOsm/L ensures that the solution is more compatible for administration through peripheral veins, aligning with clinical safety standards.

3. Patients with steroid-induced hyperglycemia should avoid what type of food?

- A. High protein foods
- B. Concentrated sweets**
- C. High fiber foods
- D. Low-fat foods

In patients with steroid-induced hyperglycemia, the primary concern is managing blood glucose levels, as steroids can lead to increased glucose production in the liver and reduced insulin sensitivity. Concentrated sweets, which include foods high in simple sugars, can cause rapid spikes in blood glucose levels. These foods are quickly absorbed and can overwhelm the body's ability to manage sugar levels, particularly in individuals already at risk for high blood sugar due to steroid use. By avoiding concentrated sweets, patients can better maintain stable blood glucose levels, which is essential in managing steroid-induced hyperglycemia. Other types of foods, such as high protein or high fiber options, generally have less of an immediate impact on blood glucose and can be more beneficial when constructing a balanced diet. Low-fat foods also do not directly contribute to hyperglycemia and may be included as part of a healthy diet. Thus, the focus should be on minimizing intake of concentrated sweets to support better glucose control.

4. Acyanotic defects primarily affect which aspect of weight in children?

- A. Length growth
- B. Weight gain**
- C. Body fat percentage
- D. Muscle mass development

In the context of acyanotic defects, the primary concern revolves around how these conditions impact a child's general growth and development, particularly related to their weight gain. Acyanotic heart defects often result in issues such as increased blood flow to the lungs and subsequently to the right side of the heart. This can lead to scenarios where children experience increased metabolic demands or interferences with their ability to feed effectively due to symptoms like fatigue or respiratory distress during feeding. Weight gain is often affected because these children may struggle to gain weight adequately despite their nutritional intake. Their higher energy expenditure related to the heart's inefficiency can prevent them from achieving appropriate growth benchmarks. In contrast, aspects like length growth, body fat percentage, and muscle mass development can also be influenced, but the most direct and critical impact often manifests in weight gain, making it the most pertinent aspect to consider in the context of acyanotic heart defects. Understanding this relationship is crucial for managing acyanotic defects in pediatrics, as ensuring proper weight gain is a significant factor in predicting overall health and developmental outcomes in children with these conditions.

5. Which behavior indicates fullness in infants aged 4 months to 6 months?

- A. Reaches for food
- B. Waves hands
- C. Falls asleep
- D. Stops sucking**

The behavior that indicates fullness in infants aged 4 months to 6 months is stopping sucking. When infants are full, they demonstrate this by ceasing to suck or actively pulling away from the breast or bottle. This natural response signifies that they have received enough nourishment and are no longer hungry. Recognizing fullness in infants is crucial for parents and caregivers, as it helps with establishing a healthy feeding routine and prevents overfeeding. In this age group, stopping sucking can also be accompanied by signs of contentment or relaxation, further confirming that the infant has satisfied their hunger. The other options, while they may reflect various behaviors or developmental milestones in infants, do not specifically indicate a state of fullness. For instance, reaching for food might suggest interest or eagerness to eat rather than the completion of a feeding. Similarly, waving hands may be a part of normal exploration or play, not necessarily tied to hunger or fullness. Falling asleep can occur due to tiredness or a soothing environment, which doesn't provide a clear signal of being full either. Thus, stopping sucking is the most definitive behavior signaling that an infant has reached their capacity for feeding at this developmental stage.

6. What is the recommended ratio of medium-chain triglycerides (MCT) in nutritional supplementation for cholestasis?

- A. 1:3
- B. 1:2
- C. 1:1**
- D. 1:4

The recommended ratio of medium-chain triglycerides (MCT) in nutritional supplementation for cholestasis is 1:1. Medium-chain triglycerides are beneficial in the context of cholestasis because they are absorbed more rapidly than long-chain triglycerides and do not require bile for absorption. This makes them particularly useful in patients where bile salt production is impaired, as is the case in cholestasis. The 1:1 ratio ensures that there is a sufficient quantity of MCT to facilitate adequate energy provision while also allowing for a balanced intake of other nutrients. This ratio supports the nutritional needs of patients, helping to prevent malnutrition, which is a common issue in those with cholestatic liver disease. In this particular context, the other ratios would not provide the optimal balance necessary for effective supplementation, potentially leading to inadequate caloric intake or inefficient nutrient absorption.

7. What is the caloric goal for enteral nutrition in term infants?

- A. 100-110kcal/kg
- B. 100-120kcal/kg
- C. 100-130kcal/kg**
- D. 90-140kcal/kg

The caloric goal for enteral nutrition in term infants is typically aimed at providing sufficient energy to support growth and development during the critical early stages of life. The correct caloric range for term infants is generally established as 100-130 kcal/kg per day. This range supports optimal growth patterns, ensuring that infants receive adequate nutrition for their high metabolic demands, development of body tissues, and overall health. Infants have unique nutritional needs due to their rapid growth rates. Providing calories beyond this range could lead to excessive weight gain, while insufficient calories can result in poor growth and developmental delays. Hence, the recommendation of 100-130 kcal/kg reflects a balance that meets the energy requirements for healthy term infants. The other ranges provided do not align as closely with established pediatric guidelines for caloric intake in infants. These guidelines take into account not just typical caloric needs but also considerations for growth, breastfeeding, and formula feeding situations.

8. In infants weighing less than 1000g, what is the limit for calcium gluconate during the first 72 hours of life?

- A. 1.0 mmol/100mL**
- B. 1.5 mmol/100mL
- C. 2.0 mmol/100mL
- D. 2.5 mmol/100mL

In infants weighing less than 1000 grams, calcium supplementation is critical in the neonatal period to promote bone health and prevent conditions like rickets. The limit for calcium gluconate during the first 72 hours of life is set at 1.0 mmol/100mL. This guideline is based on careful consideration of the infants' immature renal function and metabolic capacity, which can make them more susceptible to hypercalcemia and other complications if given excessive amounts of calcium too early. The administration of calcium gluconate needs to be carefully controlled, especially in such vulnerable populations, and guidelines are established to ensure safety while still providing adequate supplementation to meet their physiological needs. Choosing a conservative limit helps to minimize the risk of adverse effects, and practitioners typically adjust calcium administration based on the individual clinical picture and ongoing assessment of serum calcium levels. Thus, the limit of 1.0 mmol/100mL during this critical period helps protect the infant while still aiming to meet necessary nutritional requirements.

9. What is considered a preterm birth?

- A. Greater than 42 weeks
- B. Under 37 weeks**
- C. Between 37 and 42 weeks
- D. Exactly 40 weeks

A preterm birth is defined as a delivery that occurs before 37 weeks of gestation. The timeline of gestation is typically recognized as lasting up to 40 weeks, dividing pregnancy into three trimesters. Deliveries that occur after 37 weeks are classified as "term" and can be further divided into "early term" (between 37 and 38 weeks), "full term" (39 to 40 weeks), and "late term" (41 to 42 weeks). Therefore, anything below 37 weeks indicates that the baby has been delivered prematurely, which can lead to various health complications due to the underdevelopment of organs and systems. Recognizing this classification is critical in pediatrics, as it guides clinicians in anticipating potential challenges associated with preterm infants, including respiratory distress, feeding issues, and increased susceptibility to infections. Understanding gestational age at birth is key to providing appropriate monitoring and interventions for infants born prematurely.

10. What ratio is used for adding phosphorus to calcium in infants?

- A. 1:3 ratio
- B. 1:5 ratio
- C. 1:7 ratio**
- D. 1:9 ratio

The correct ratio for adding phosphorus to calcium in the diet of infants is based on the nutritional guidelines that support optimal bone development and growth during this critical period. In infancy, the recommended calcium to phosphorus ratio is approximately 2:1. This translates to a phosphorus to calcium ratio of about 1:2, which is often expressed inversely as 1:3 when discussing the amounts of calcium added relative to phosphorus. Since phosphorus is essential for bone health and works synergistically with calcium, the appropriate balance ensures not just adequate levels of both minerals but also promotes proper metabolism and absorption. The nutritional guidelines indicate that for every 1 part of phosphorus, there should be about 3 parts of calcium, hence the rationale behind the 1:3 ratio is to provide sufficient calcium that supports the phosphorus requirements without leading to an imbalance. Factors such as ensuring adequate calcium levels while preventing excessive phosphorus are crucial, as high phosphorus relative to calcium can lead to negative health outcomes, including impaired bone mineralization.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://specialistinpediatrics.examzify.com>

We wish you the very best on your exam journey. You've got this!

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