value. Record immediately.

Special considerations (Foote, Brady, Burke, et al, 2014; Lohman, Roche, and Martorell, 1988).

- Some children, such as those who are obese, may not be able to place their occiput, scapulae, buttocks, and heels all in one vertical plane while maintaining their balance, so use at least two of the four contact points.

- If a child has a leg length discrepancy, place a block or wedge of suitable height under the shortest leg until the pelvis is level and both knees are fully extended before measuring height. To measure length, keep the legs together and measure to the heel of the longest leg.

- Children with special health care needs may require alternative measurements, such as arm span, crown-rump length, sitting height, knee height, or other segmental lengths. In general, when recumbent length is measured in a child with spasticity or contractures, measure the side of the body that is unaffected or less affected.

- Always document the presence of any condition that may interfere with accurate and reliable linear growth measurement.

Quality control measures (Brady, Burke, et al, 2014; Foote, 2014).

- Personnel who measure the growth of infants, children, and adolescents need proper education. Competency should be demonstrated. Refresher sessions should occur when a lack of standardization occurs.

- Length boards and stadiometers must be assembled and installed properly and calibrated at regular intervals (ideally daily, at least monthly, and every time they are moved) due to frequent inaccuracy and the variability between different instruments. Calibration can be performed by measuring a rod of known length and adjusting the instrument accordingly.