REGION 7

Emergency Medical Services Systems

Advocate Christ Medical Center EMS System
Morris EMS System
Ascension Saint Mary's-Kankakee EMS System
Riverside EMS System
Silver Cross EMS System
South Cook County EMS System

EMERGENCY MEDICAL RESPONDER
Standing Medical Orders

REVISED: May 28,2025
Effective: January 1st, 2007

REGION 7
EMERGENCY MEDICAL SERVICES SYSTEMS
EMERGENCY MEDICAL RESPONDER
STANDING MEDICAL ORDERS

These orders are to be used as the prehospital treatment protocols. They are to be followed by all Emergency Medical Responder (EMR) members of the EMS System. We have incorporated evidence-based guidelines with historically proven practices to produce them. While it is impossible to address every possible variation of disease or traumatic injury, these protocols do provide a foundation for treating the vast majority of patients we encounter. Certainly our education, experience, and clinical judgment will assist us as we strive to provide the highest quality prehospital patient care. Deviations from these orders can be made only by the EMS Medical Director or designee.

These orders are to be used in the following situations:

- **When the initiation of care begins before hospital communication is established.**
- **In the event that communications cannot be established or communication is disrupted or lost between the responding paramedics and their directing hospital. Every effort should be made to contact the hospital over the telemetry radio, MERCI radio, cellular phone or landline phone.**
- **In disaster situations, when immediate action to preserve lives and limbs supersedes the need to communicate directly with the hospital.**

Never delay patient transport awaiting ALS/ILS/BLS backup if the ETA of the backup is greater than the ETA to the closest appropriate hospital .

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PROTOCOL SYMBOL KEY

>	greater than
≥	greater than or equal to
<	less than
≤	less than or equal to
	enter from or exit to another protocol

APPENDIX A PAGE 1 AND 2 WEIGHT CONVERSION TABLE POUNDS TO KILOGRAMS

Protocol 1

INITIAL MEDICAL CARE / ROUTINE CARDIAC CARE

GENERAL PATIENT ASSESSMENT

- Prehospital providers shall always assess the scene to assure the safety of all personnel.
- Patient care and treatment begins at the "bedside."
- Prehospital personnel shall take all reasonable precautions to prevent exposure to blood and/or body fluids of any patient. Use fluid repellent gowns, masks and goggles as situation dictates.

GENERAL PATIENT ASSESSMENT

Initial Assessment:

1. Circulation (pulse) and hemorrhage control (if indicated)
2. Airway - Establish and/or maintain an airway (cervical spine control, if indicated)
3. Breathing - Assist ventilation as required
4. Disability (Level of Consciousness)
   - "Alert"
   - "Verbal" - (responds to verbal stimuli)
   - "Pain" - (responds to painful stimuli)
   - "Unresponsive"
5. Expose and examine (if indicated)

Focused Assessment:

1. Vital signs, and where applicable, Glasgow Coma Scoring parameters
2 Systematic head - to - toe detailed assessment
3. History of present illness/injury

INITIAL MEDICAL CARE/ROUTINE CARDIAC CARE

1. Reassure patient, provide comfort and loosen tight clothing.
2. Sit patient in semi-Fowler's or position of comfort (if applicable).
3. Obtain Pulse Oximeter value (when available) prior to oxygen delivery. Deliver OXYGEN 2-6L by nasal cannula or 12-15L by mask, if needed.
4. Contact hospital as soon as patient's condition permits. Transmit assessment information and await orders. If no radio contact can be established or patient's condition requires immediate treatment, refer to appropriate protocol and begin intervention immediately.
5. Recheck vitals and other pertinent signs at least every 15 minutes and record, note the times.
6. **EMERGENCY MEDICAL RESPONDER consider ALS mutual aid**

NOTE: In a combative or uncooperative patient, the requirement to initiate initial routine medical care, as written, may be altered or waived in favor of rapidly transporting the patient for definitive care. Document the patient's actions or behaviors which interfered with the performance of any assessments and/or interventions.

Protocol 2

RADIO REPORT

OUTLINE FOR RADIO REPORT (Transmit using as few words as possible)

1. Name and vehicle number of provider
2. Requested destination, closest appropriate hospital and estimated time of arrival
3. Age, sex, and approximate weight of patient
4. Chief Complaint, to include symptoms and degree of distress
5. History of present illness/injury
6. Pertinent Medical History:
   - Allergies
   - Medications
   - Past History of current illness
   - Last Meal
   - Events surrounding incident
7. Clinical condition:
   - Focused and detailed patient assessment findings
8. Treatment initiated and response

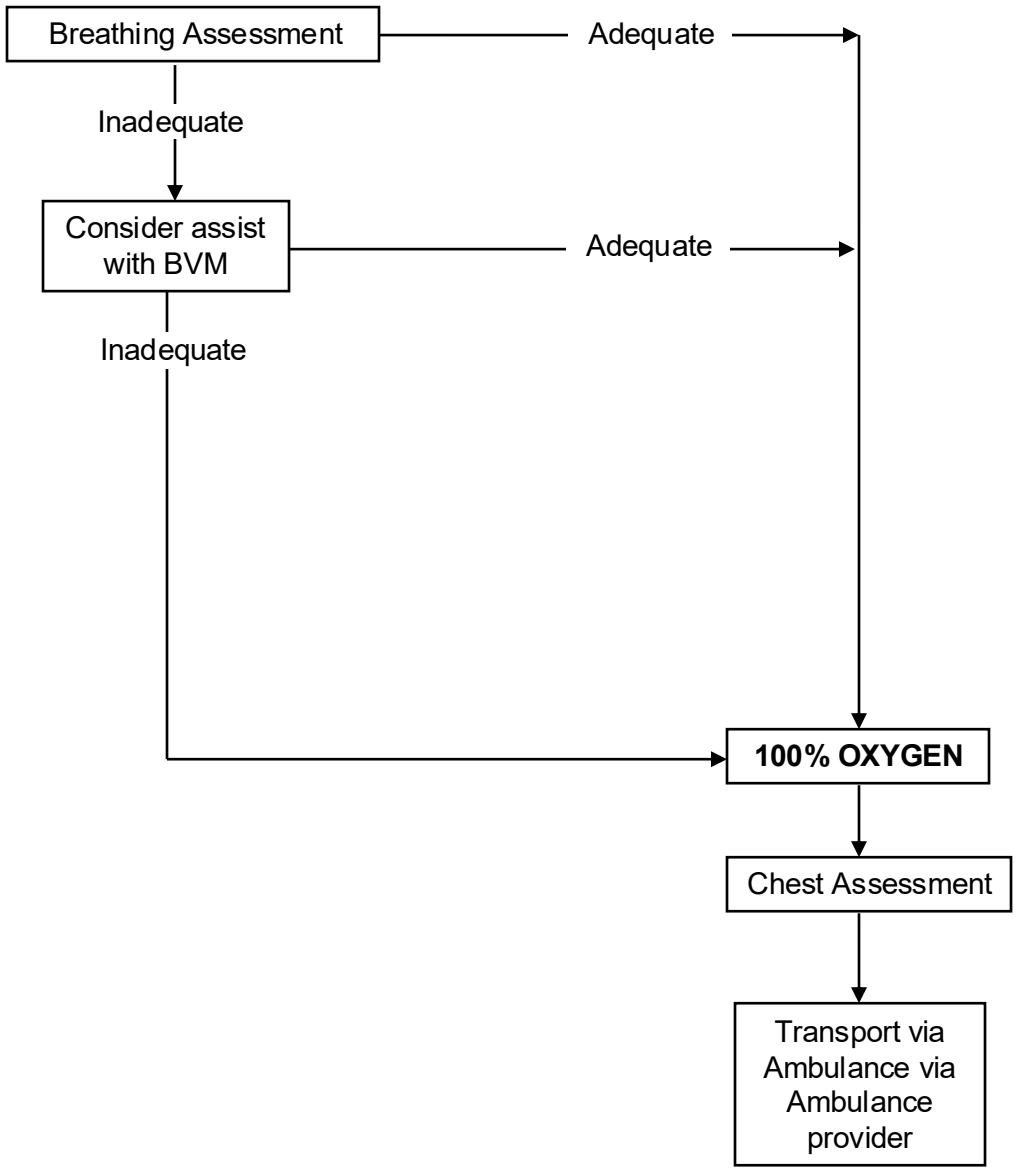
The use of an abbreviated report is optional. A full report may always be given at the discretion of the prehospital provider. A full report must always be given:

- when vital signs are unstable,
- when any treatment has been initiated other than OXYGEN

Refer to and follow the steps under **GENERAL PATIENT ASSESSMENT** and **INITIAL MEDICAL CARE / ROUTINE CARDIAC CARE**.

Protocol 3

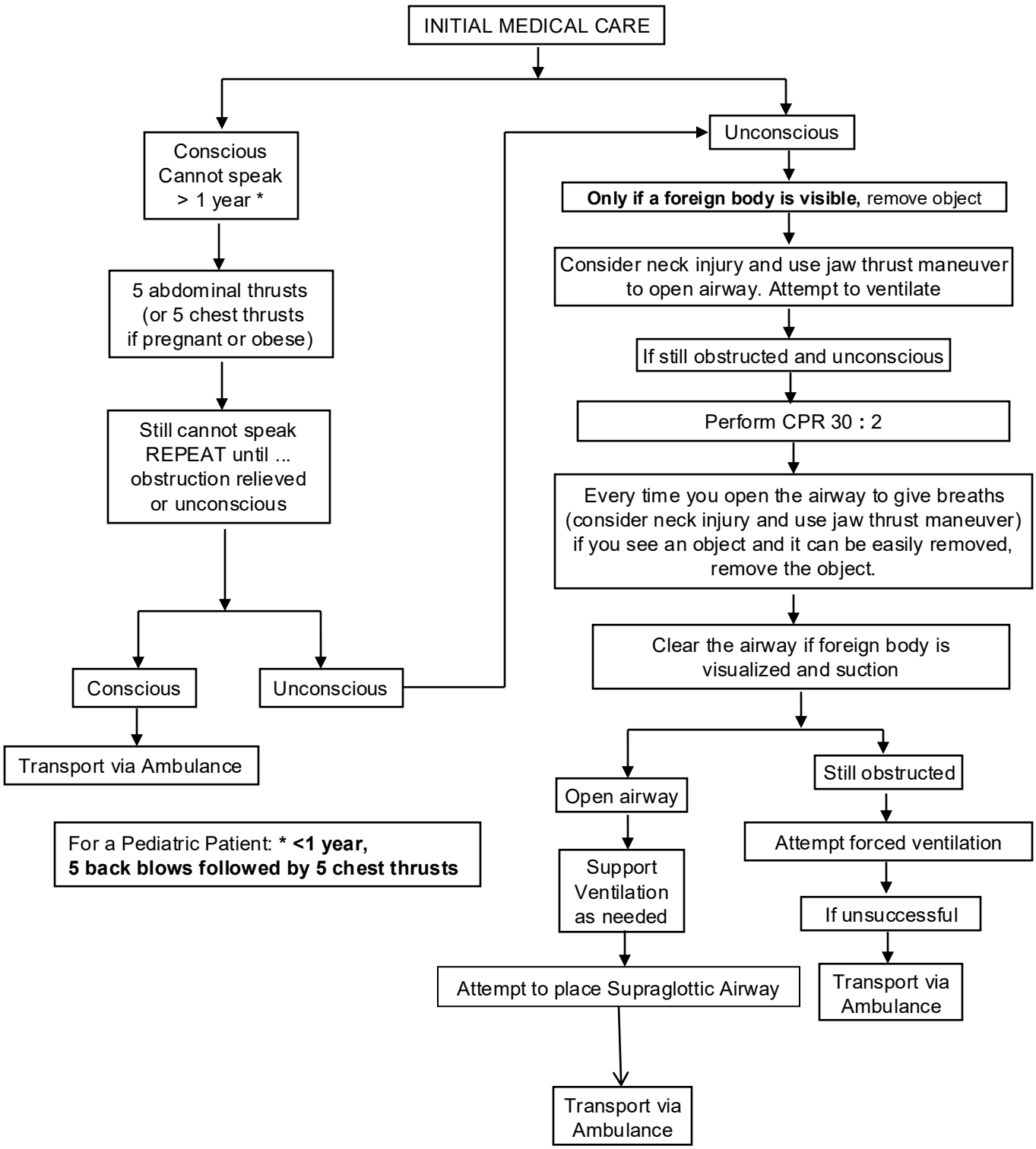
ADULT RESPIRATORY DISTRESS



For a pediatric patient refer to **PEDIATRIC RESPIRATORY DISTRESS PROTOCOL #61**

Protocol 4

AIRWAY OBSTRUCTION



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EMR

Protocol 5

PAIN CONTROL

Enter from protocol based on **Specific Complaint** ◇

↓

Assess Pain Severity

Use combination of
Pain Scale, Circumstances, MOI, Injury or Illness severity

↓

Allow for position of maximum comfort unless contraindicated

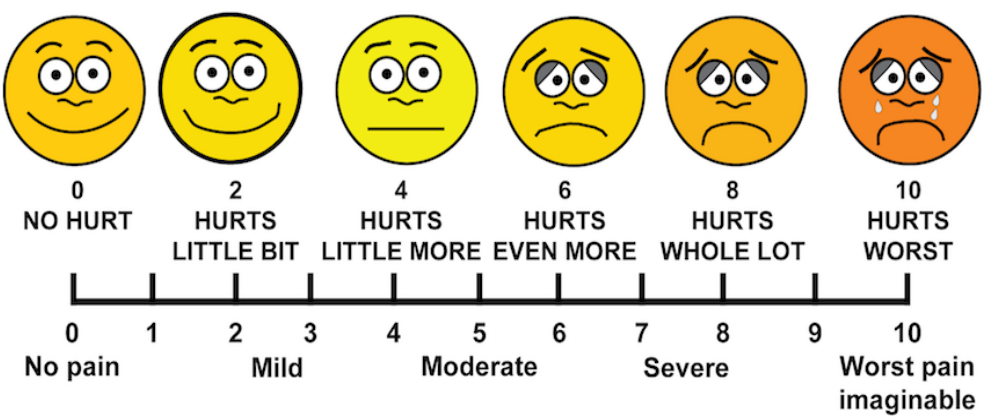
↓

Monitor and Reassess

↓

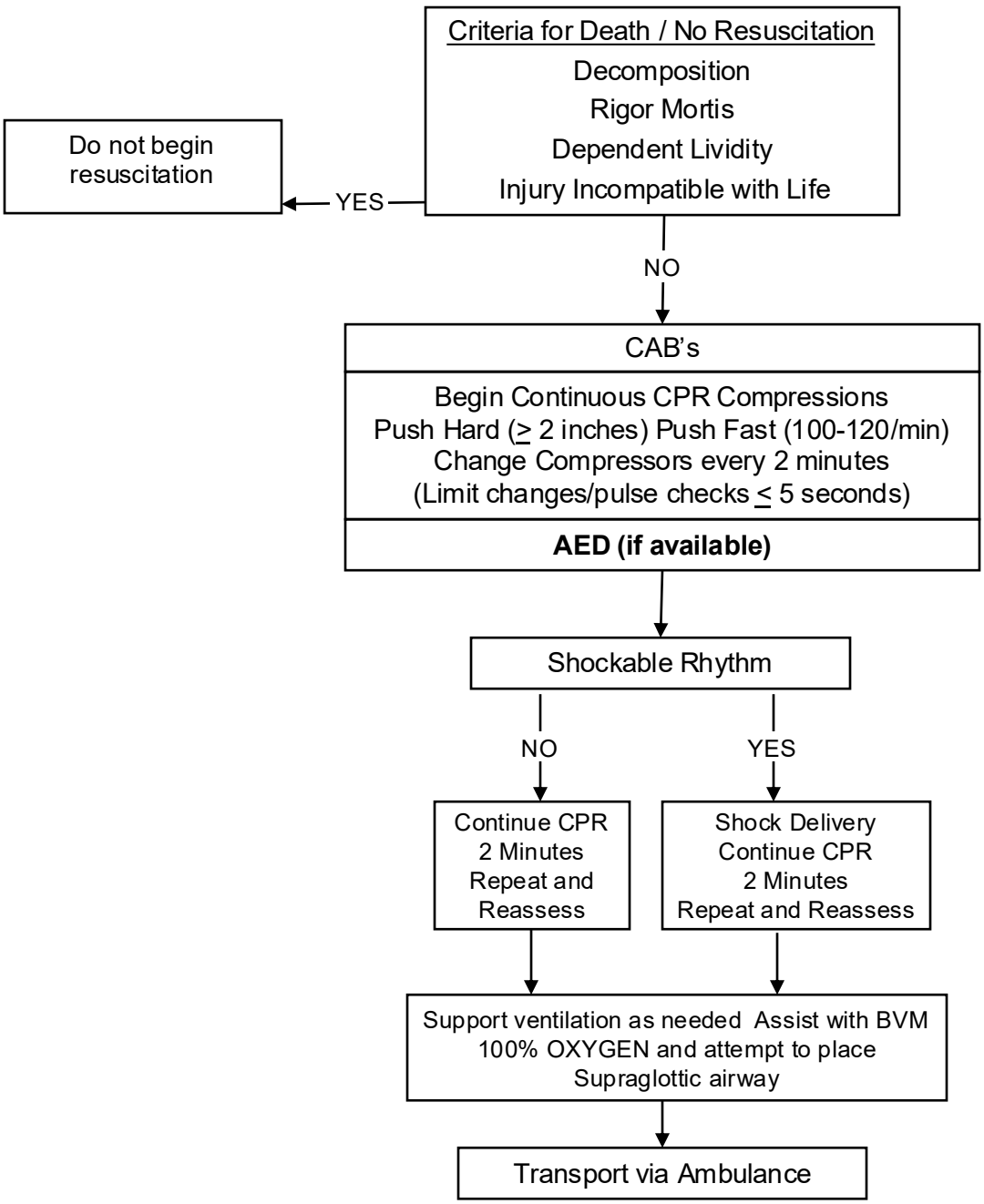
Transport via Ambulance

PAIN MEASUREMENT SCALE



Protocol 6

ADULT CARDIAC ARREST



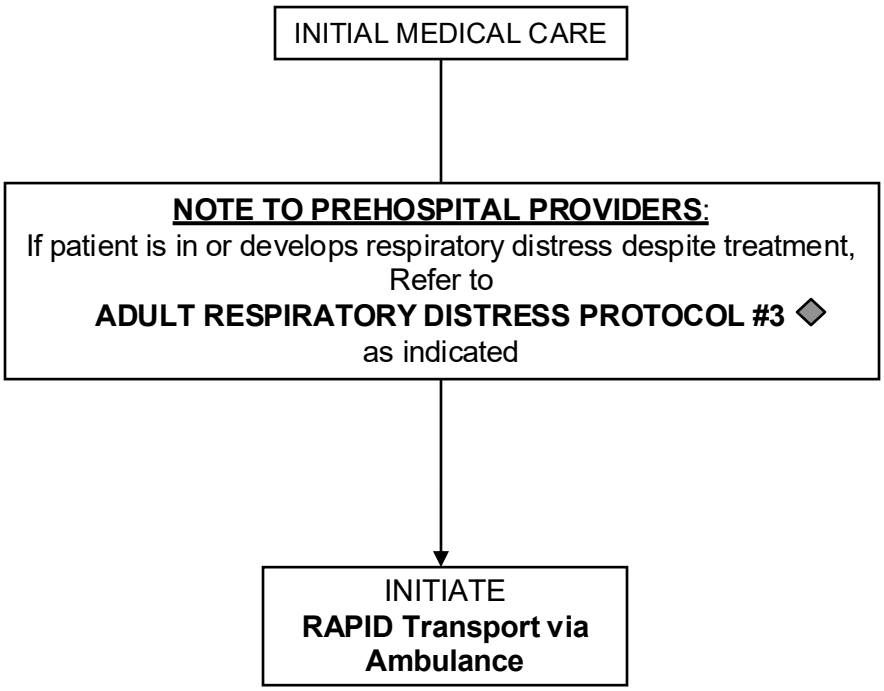
AT ANY TIME
Return of Spontaneous Circulation
Continue CAB monitoring and support

For a pediatric patient refer to **PEDIATRIC CARDIAC ARREST PROTOCOL #58** ◈

Revised 5/28/2025
EMR

Protocol 7

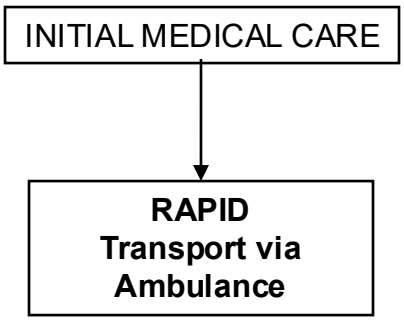
ADULT CARDIOGENIC SHOCK



For a pediatric patient refer to **PEDIATRIC SHOCK PROTOCOL #63**

Protocol 9

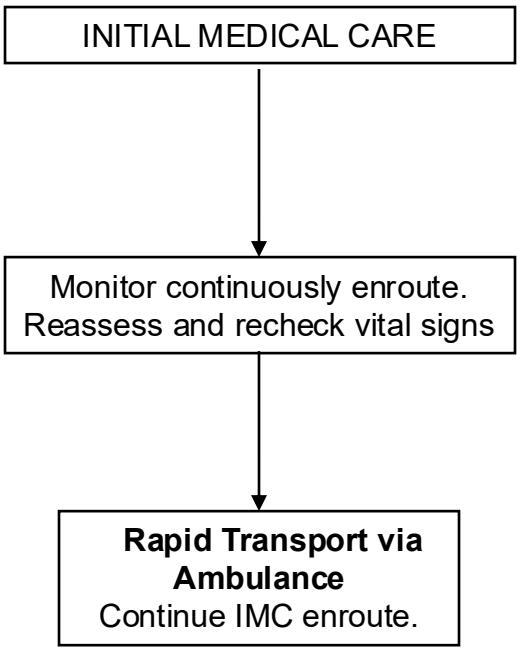
ADULT TACHYCARDIAS (WITH PULSE)



For a pediatric patient refer to **PEDIATRIC TACHYCARDIA PROTOCOL #60**

Protocol 12

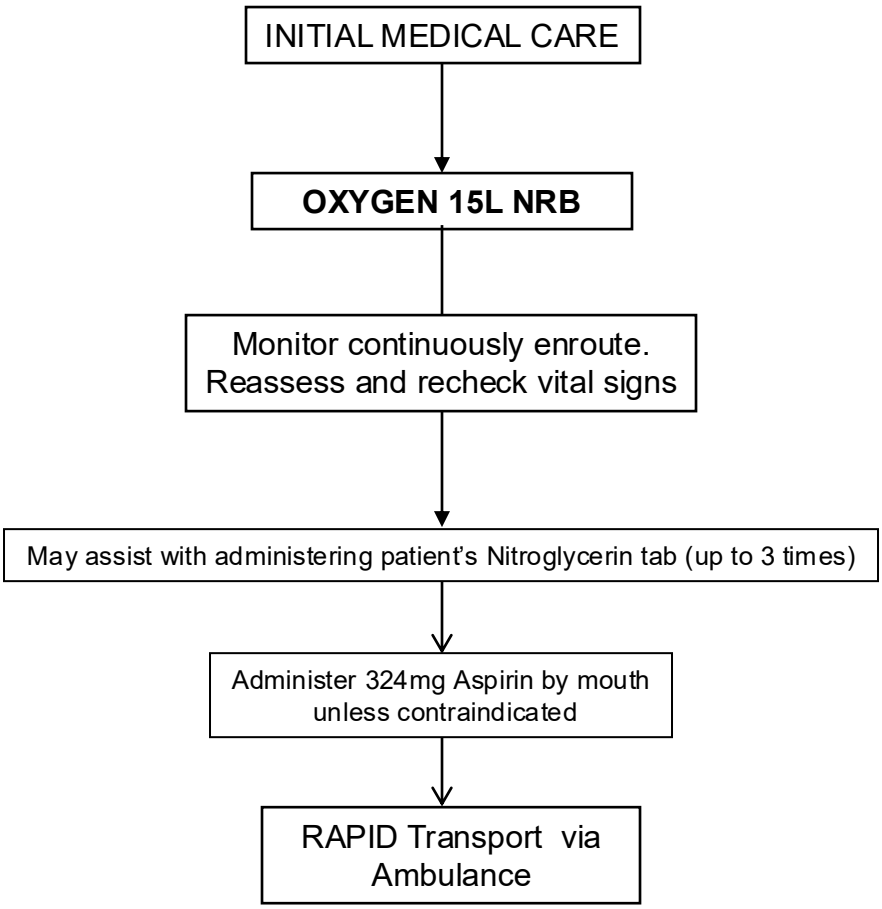
ADULT BRADYCARDIA (PULSE < 60)



For a pediatric patient refer to **PEDIATRIC BRADYCARDIA PROTOCOL #59**

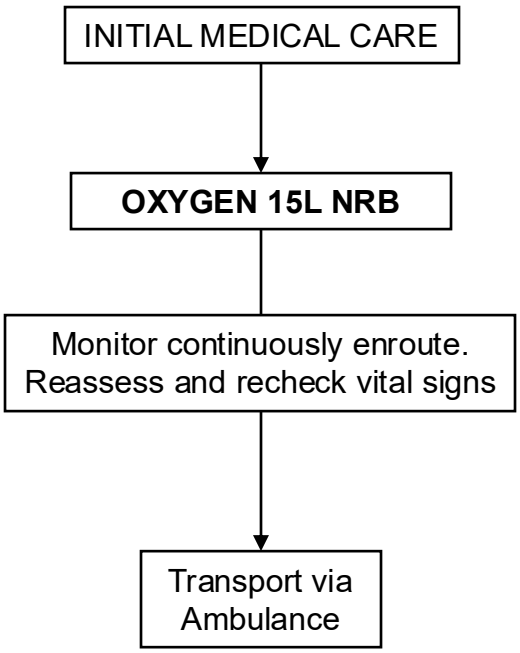
Protocol 13

ADULT SUSPECTED CARDIAC PATIENT



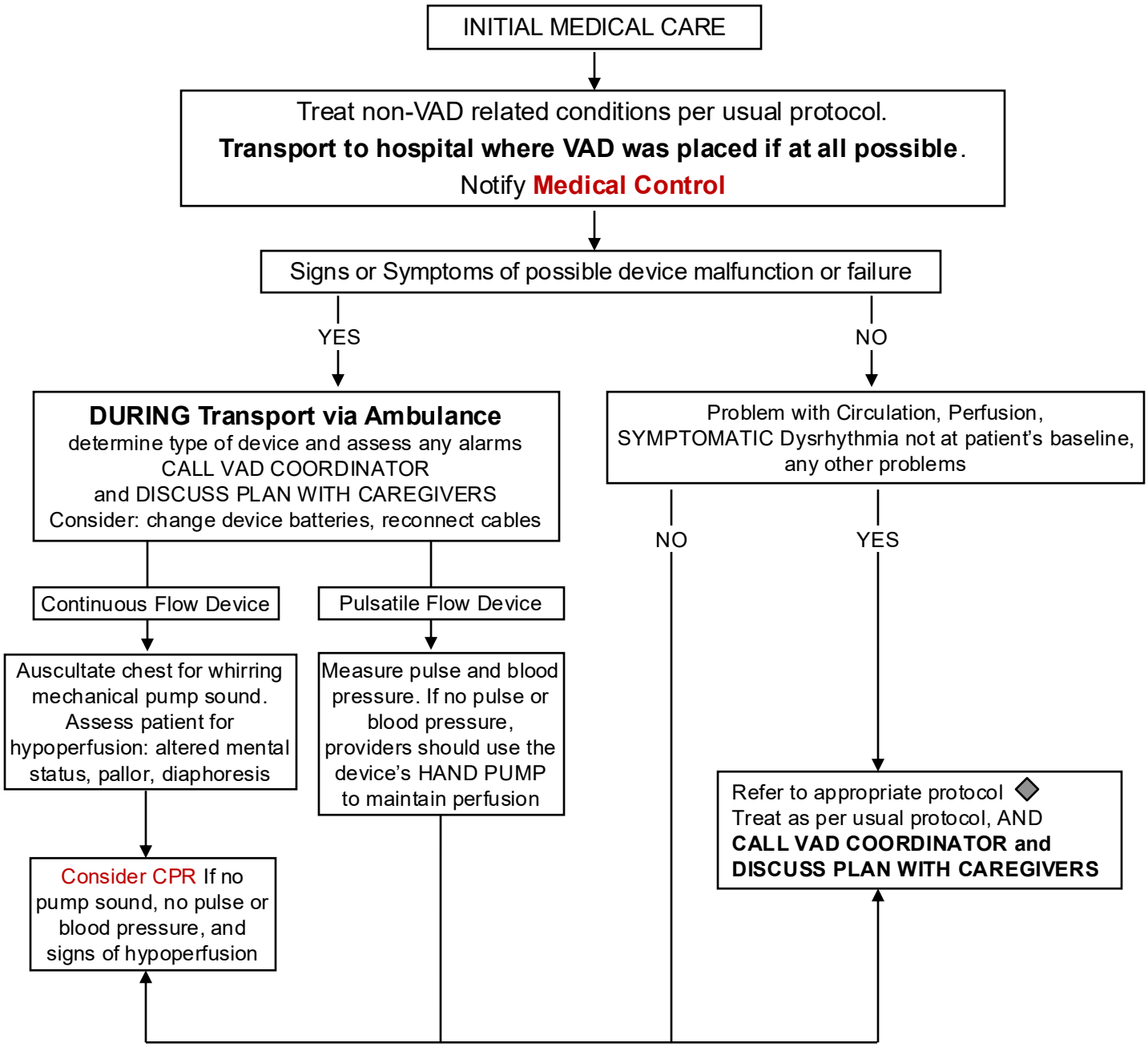
Protocol 14

ADULT PULMONARY EDEMA DUE TO HEART FAILURE



Protocol 15

VENTRICULAR ASSIST DEVICES (VAD/LVAD)



TRAUMA

Protocol 16

FIELD TRIAGE PROTOCOLS

PATIENTS BEING BYPASSED TO A TRAUMA CENTER MUST BE ADEQUATELY VENTILATED. IF UNABLE TO BE VENTILATED, THE PATIENT SHOULD BE TRANSPORTED TO THE CLOSEST COMPREHENSIVE EMERGENCY DEPARTMENT.

IF TRANSPORT TO THE NEAREST TRAUMA CENTER IS GREATER THAN 30 MINUTES, TRANSPORT TO THE NEAREST EMERGENCY DEPARTMENT.

National Guideline for the Field Triage of Injured Patients

RED CRITERIA = CATEGORY I
High Risk for Serious Injury

Injury Patterns

- Penetrating injuries to head, neck, torso, and proximal extremities
- Skull deformity, suspected skull fracture
- Suspected spinal injury with new motor or sensory loss
- Chest wall instability, deformity, or suspected flail chest
- Suspected pelvic fracture
- Suspected fracture of two or more proximal long bones
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

Mental Status & Vital Signs

All Patients

- Unable to follow commands (motor GCS < 6)
- RR < 10 or > 29 breaths/min
- Respiratory distress or need for respiratory support
- Room-air pulse oximetry < 90%

Age 0-9 years

- SBP < 70mm Hg + (2 x age years)

Age 10-64 years

- SBP < 90mmHg OR
- HR > SBP

Age ≥ 65 years

- SBP < 110 mmHg OR
- HR > SBP

The above CATEGORY I criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system.

YELLOW CRITERIA = CATEGORY II
Moderate Risk for Serious Injury

Mechanism of Injury

- High-Risk Auto Crash
  - Partial or complete ejection
  - Significant intrusion (including roof)
    - >12 inches occupant site OR
    - >18 inches any site OR
    - Need for extrication for entrapped patient
  - Death in passenger compartment
  - Child (Age 0-9) unrestrained or in unsecured child safety seat
  - Vehicle telemetry data consistent with severe injury
- Rider separated from transport vehicle with significant impact (e.g. motorcycle, ATV, horse, etc.)
- Pedestrian/bicycle rider thrown, run over, or with significant impact
- Fall from height > 10 feet (all ages)

EMS Judgment

Consider risk factors, including:

- Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact
- Anticoagulant use
- Suspicion of child abuse
- Special, high-resource healthcare needs
- Pregnancy > 20 weeks
- Burns in conjunction with trauma
- Children should be triaged preferentially to pediatric capable centers

If concerned, take to a trauma center

Patients meeting any one of the CATEGORY II criteria who do not meet CATEGORY I criteria should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center).

Protocol 17

REVISED TRAUMA SCORE/GLASGOW COMA SCALE

A standard procedure for assessing revised trauma scores in the field is necessary so that the reliability of that revised trauma score is recognized by both field personnel and emergency department personnel.

The patient is scored by assessing the following vital functions and computing a score - the **REVISED TRAUMA SCORE**.

1. Respiratory rate
2. Systolic blood pressure
3. Glasgow coma scale

For the Glasgow Coma Scale, the examiner determines the best response the patient can make to a set of standardized stimuli.

1. Eye opening: The examiner determines the minimum stimulus that evokes opening of one or both eyes.
   a. (4 points) SPONTANEOUS
   b. (3 points) VOICE
   c. (2 points) PRESSURE
   d. (1 point) NONE

Note: If the patient cannot open the eyes because of bandages, edema or direct trauma, please note and document in the patient's record.

2. Best Verbal Response: The examiner determines the BEST response after arousal:
   a. (5 points) ORIENTED
   b. (4 points) CONFUSED
   c. (3 points) INAPPROPRIATE WORDS
   d. (2 points) INCOMPREHENSIBLE SOUNDS
   e. (1 point) NO VERBAL RESPONSE

Note: If the patient is intubated, dysphasic or has maxillofacial injuries which may preclude a verbal response, the examiners assessment should be documented in the patient's record.

3. Best Motor Response: The examiner determines the BEST movement from either arm in response to stimulus.
   a. (6 points) OBEYS SIMPLE COMMANDS
   b. (5 points) LOCALIZES PAIN
   c. (4 points) FLEXION WITHDRAWAL
   d. (3 points) ABNORMAL FLEXION
   e. (2 points) ABNORMAL EXTENSION
   f. (1 point) NO MOTOR RESPONSE

Note: If the patient has suspected or known spinal cord injury, this neurologic deficit should be noted in the patient’s record.

The components necessary to calculate the Revised Trauma Score and Glasgow Coma Scale will be obtained by prehospital personnel. The actual calculation of these scores will be performed by **Medical Control**. These scores are to be obtained when the need for transport to a trauma center is questionable.

Protocol 18

ROUTINE TRAUMA CARE
PAGE 1 OF 2

1. Prehospital providers shall always assess the scene to assure the safety of all personnel.
2. Patient care and treatment begins at the scene.
3. Prehospital personnel shall take all reasonable precautions to prevent exposure to blood and/or body fluids of any patient. Use fluid repellent gloves, gowns, masks and goggles, as situation dictates.

PRIMARY PATIENT ASSESSMENT

1. ESTABLISH LEVEL OF RESPONSIVENESS
   - Brief history: Any dyspnea or pain?
2. IMMOBILIZE C-SPINE
   - Manual immobilization initially
   - Rigid collar, Cervical Immobilization Device, and spinal motion restriction as indicated prior to transport (Refer to **SPINAL INJURY PROTOCOL #20)** ◆
3. CIRCULATION (Refer to the **ADULT HEMORRHAGIC SHOCK PROTOCOL #19** ◆ or the **PEDIATRIC SHOCK PROTOCOL # 63**) ◆
   - Life threatening hemorrhage - <u>STOP THE BLEEDING</u>.
     For uncontrolled hemorrhage, use a tourniquet when needed or consider a hemostatic dressing (if available)
   - Peripheral pulses (weak, thready, absent)
   - Capillary refill (if delayed)
4. CHECK THE NECK
   - Carotid pulses
     If absent: CPR, minimize scene time (Refer to **TRAUMATIC CARDIOPULMONARY ARREST PROTOCOL #22)** ◆
   - Tracheal deviation (Refer to **CHEST TRAUMA PROTOCOL #28)** ◆
   - JVD (Refer to **CHEST TRAUMA PROTOCOL #28)** ◆
5. AIRWAY (If obstructed Refer to **AIRWAY OBSTRUCTION PROTOCOL #4)** ◆
   - Open or secure as needed
6. BREATHING (Refer to **CHEST TRAUMA PROTOCOL #28** ◆ and either the **ADULT RESPIRATORY DISTRESS PROTOCOL #3** ◆ or the **PEDIATRIC RESPIRATORY DISTRESS PROTOCOL # 61**) ◆
   - <u>ASSIST VENTILATION</u> AS REQUIRED
   - Inspect the chest
   - Palpate the chest
   - Auscultate the chest (including the heart)
7. NEUROLOGIC DEFICIT (Refer to **HEAD TRAUMA / UNCONSCIOUS PATIENT PROTOCOL #21)** ◆
   - AVPU
   - Motor & Sensory
   - Pupils

Protocol 18

ROUTINE TRAUMA CARE
PAGE 2 OF 2

SECONDARY PATIENT ASSESSMENT

1. Vital Signs
2. GCS scoring parameters
3. Systematic head to toe assessment
4. Medications
5. Allergies
6. Reassure patient, provide comfort, loosen tight clothing, and keep patient warm.
7. Evaluate cardiac rhythm, if indicated. (All ALS patients do not necessarily require continuous ECG monitoring or transmission of a strip to the hospital.)
8. Contact hospital as soon as patient's condition permits. Transmit assessment information and await orders.

   If no radio contact can be established or patient's condition requires immediate treatment, refer to appropriate protocol ◇ and begin intervention immediately.
9. Recheck vitals and other pertinent signs and symptoms at least every 15 minutes and record, noting times.

   If unstable vital signs/sustained hypotension (SBP <90 on two separate readings 5 minutes apart), vital signs should be taken and recorded every 5 minutes.
10. All patients, who, in the judgment of prehospital personnel, would benefit from care derived from a Trauma Center, should be transported accordingly (Refer to **FIELD TRIAGE PROTOCOLS #16**). ◇

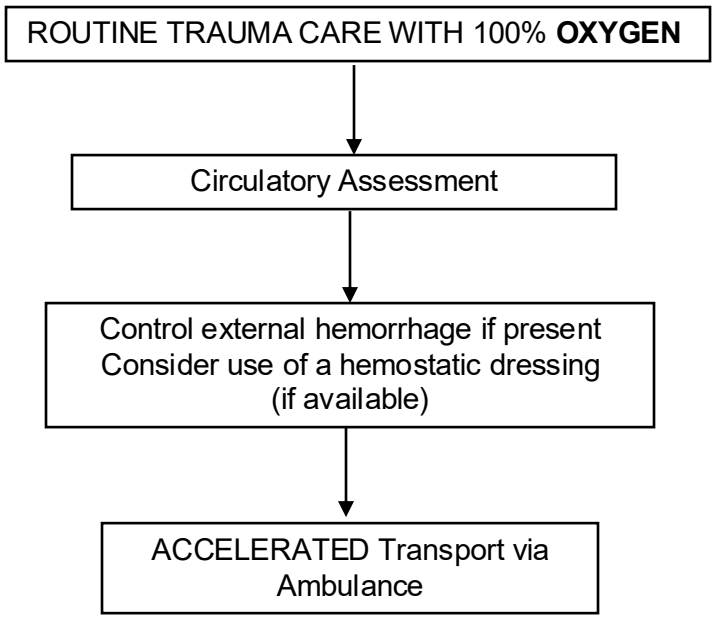
    If unable to ventilate, transport to nearest hospital.

NOTE TO PREHOSPITAL PROVIDERS:

In a combative or uncooperative patient, the requirement to initiate initial routine trauma care, as written, may be altered or waived in favor of rapidly transporting the patient for definitive care. Document the patient's actions or behaviors which interfered with the performance of any assessments and/or interventions.

Protocol 19

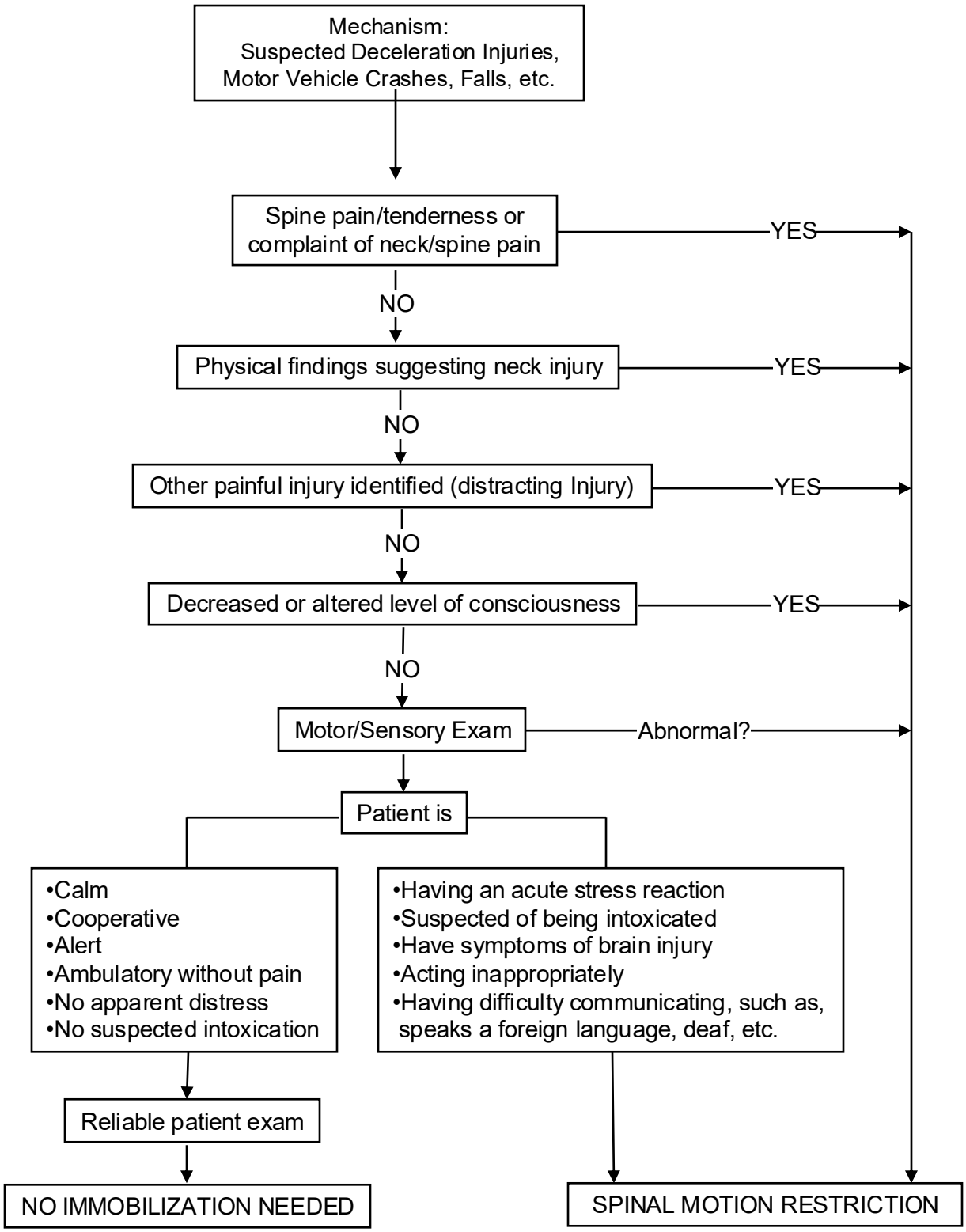
ADULT HEMORRHAGIC SHOCK



For a pediatric patient refer to **PEDIATRIC SHOCK PROTOCOL #63**

Protocol 20

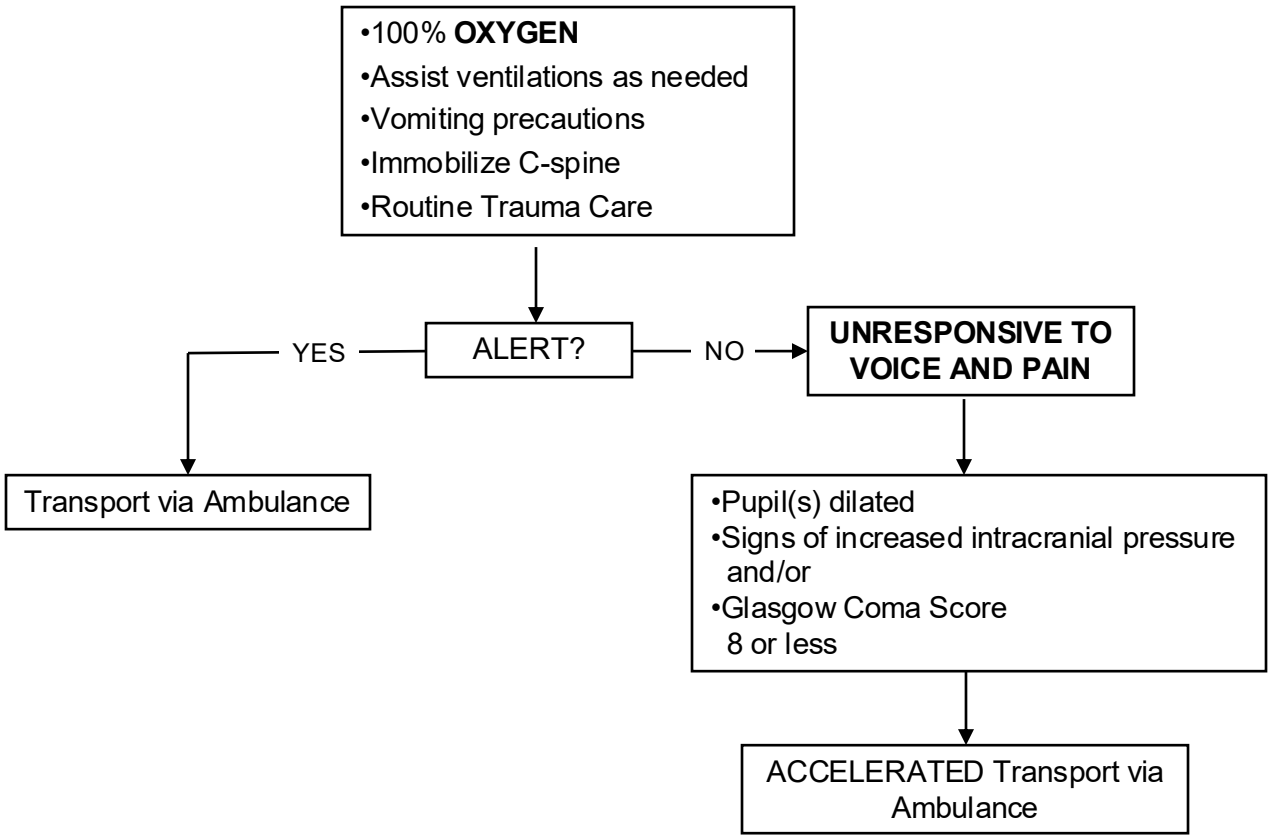
SPINE INJURY



NOTE TO PREHOSPITAL PROVIDERS:
SPINAL MOTION RESTRICTION includes placement of cervical collar and securing patient supine on stretcher. Long board use should be reserved for patients in whom a reliable exam cannot be obtained, multiple long bone fractures, or other injury in which transportation would be difficult or delayed without use of long board.

Protocol 21

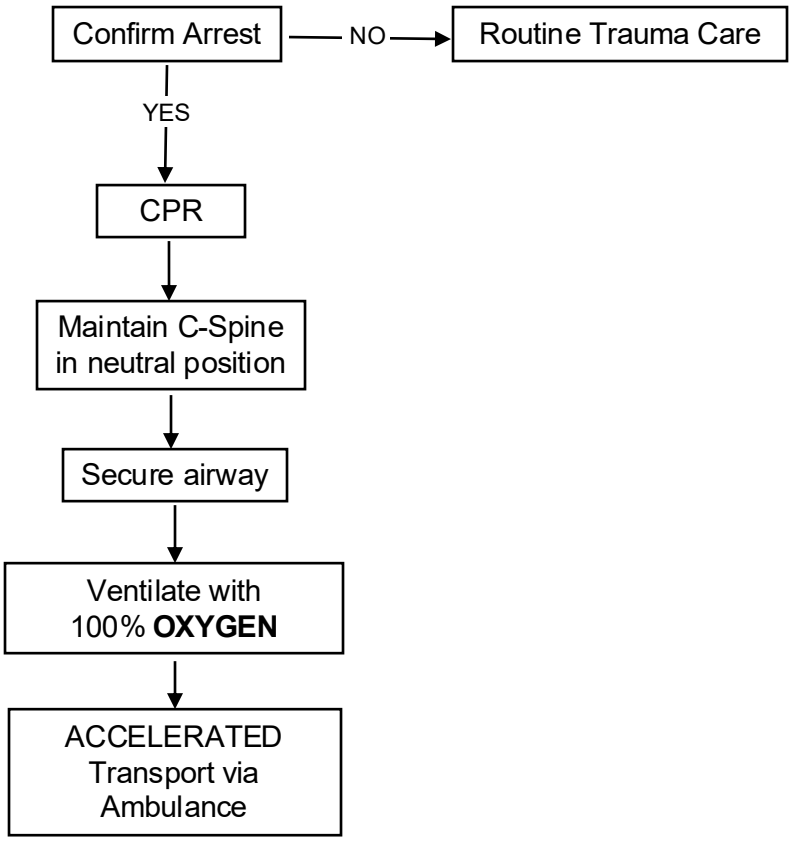
HEAD TRAUMA/UNCONSCIOUS PATIENT



NOTE TO PREHOSPITAL PROVIDERS:
If unequal or fixed pupils and/or posturing, ventilate at 20 breaths/min.

Protocol 22

TRAUMATIC CARDIOPULMONARY ARREST



Protocol 23

ADULT ISOLATED EXTREMITY INJURY AND/OR AMPUTATED AND AVULSED PARTS

INITIAL TRAUMA CARE
(CABs always take priority over the severed part)

↓

Control bleeding with direct pressure and elevation

For uncontrolled hemorrhage:

- Consider use of a hemostatic agent (if available)
- Use a tourniquet if needed
  - Note time of placement
  - Apply as close to the injury as possible
  - DO NOT release once applied

↓

Refer to **ADULT PAIN CONTROL PROTOCOL #5** ◇

↓

- Wrap part in sterile gauze, sheet or towel.
- Place part in waterproof bag or container and seal.
- DO NOT immerse part in any solutions.
- Place this container in a second one filled with ice, cold water or cold pack.

↓

Transport part to hospital with patient

↓

Transport via Ambulance

Protocol 24

ADULT CRUSH INJURY

Suspected in extended entrapment of extremity and/or torso

↓

Check for:

Pain – Paresthesia – Paralysis – Pallor – Pulselessness

Not needed but good indicators

↓

INITIAL MEDICAL CARE

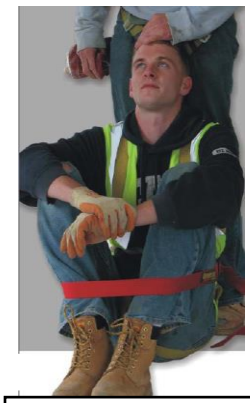
↓

Transport via Ambulance

Protocol 25

ADULT SUSPENSION TRAUMA

Suspension trauma is a term used to describe the condition where a person is trapped in an upright position while using a safety harness for fall protection.



Check for:

Pain – Paresthesia – Paralysis – Pallor – Pulselessness

Not needed but good indicators

↓

INITIAL MEDICAL CARE

↓

W-position

AIRWAY AS NEEDED

Do NOT allow the patient to lie flat or stand up

Provide oxygen at 100% for all patients

Manually stabilize the C-Spine via all possible means (KED), but do not lie the patient flat

FULLY CONSCIOUS and MOBILE:

Place patient in a safe position which is,

sitting upright with the legs bent at the waist ('W-position') for 30 minutes

↓

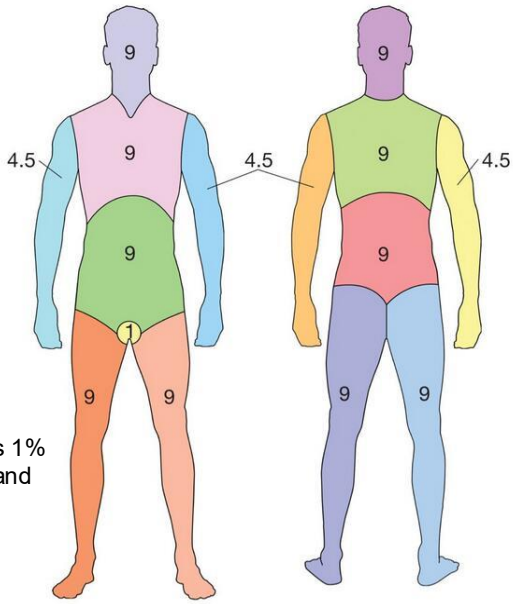
Transport via Ambulance

Transport patient, in sitting position, to nearest hospital unless in arrest

TRAUMA

Protocol 27

ADULT BURNS



Burn patients are often victims of multiple trauma.
Treatment of major traumatic injuries takes precedence over wound management. **Isolated burn injury patients should be transferred to the closest appropriate hospital**

ASSESS

•Total body surface area: use rule of 9s or estimate using patient's palmar surface as 1%
•Depth of burn: partial or full thickness, consider exposure to products of combustion and treat as soon as possible.

THERMAL

INITIAL TRAUMA CARE

OXYGEN 100% Use humidified Oxygen, (if available).
Note presence of hoarseness, wheezing, stridor or productive cough and document.
If present, refer to **ACCELERATED Transport via Ambulance PROTOCOL #26** ◇

Note quality of distal pulse in extremity burns and document.

Burn Wound Care - Moderate to Critical Burn

Wear sterile gloves and mask until burn wounds are covered.
Remove clothing, jewelry, etc.
Do not pull away clothing that is stuck to burn wound.

Cover burn wound with sterile dressing.
DO NOT BREAK BLISTERS. DO NOT APPLY CREAMS, OINTMENTS OR ANTIDOTES TO BURNS.

Open sterile sheet on stretcher before placing patient for Transport via Ambulance.
Cover patient with dry, sterile sheets and blanket to maintain body temperature.

CHEMICAL

INITIAL TRAUMA CARE

Brush off excess dry chemicals

Irrigate or flush with copious amounts of water or saline unless contraindicated.

For eye exposures Refer to **HAZARDOUS MATERIALS-EYE PROTOCOL #44** ◇

Follow routine Burn Wound Care

Transport via Ambulance

ELECTRICAL

Without placing self at risk for injury, remove patient from source of electricity or have power cut off.

INITIAL TRAUMA CARE

Immobilization (as indicated)
Refer to **SPINE INJURY PROTOCOL #23** ◇
Apply monitor and treat dysrhythmias per appropriate protocol.

Burn Wound Care

Assess for entry and exit wounds and neurovascular status of affected parts.

No cooling necessary

Cover with dry, sterile dressings

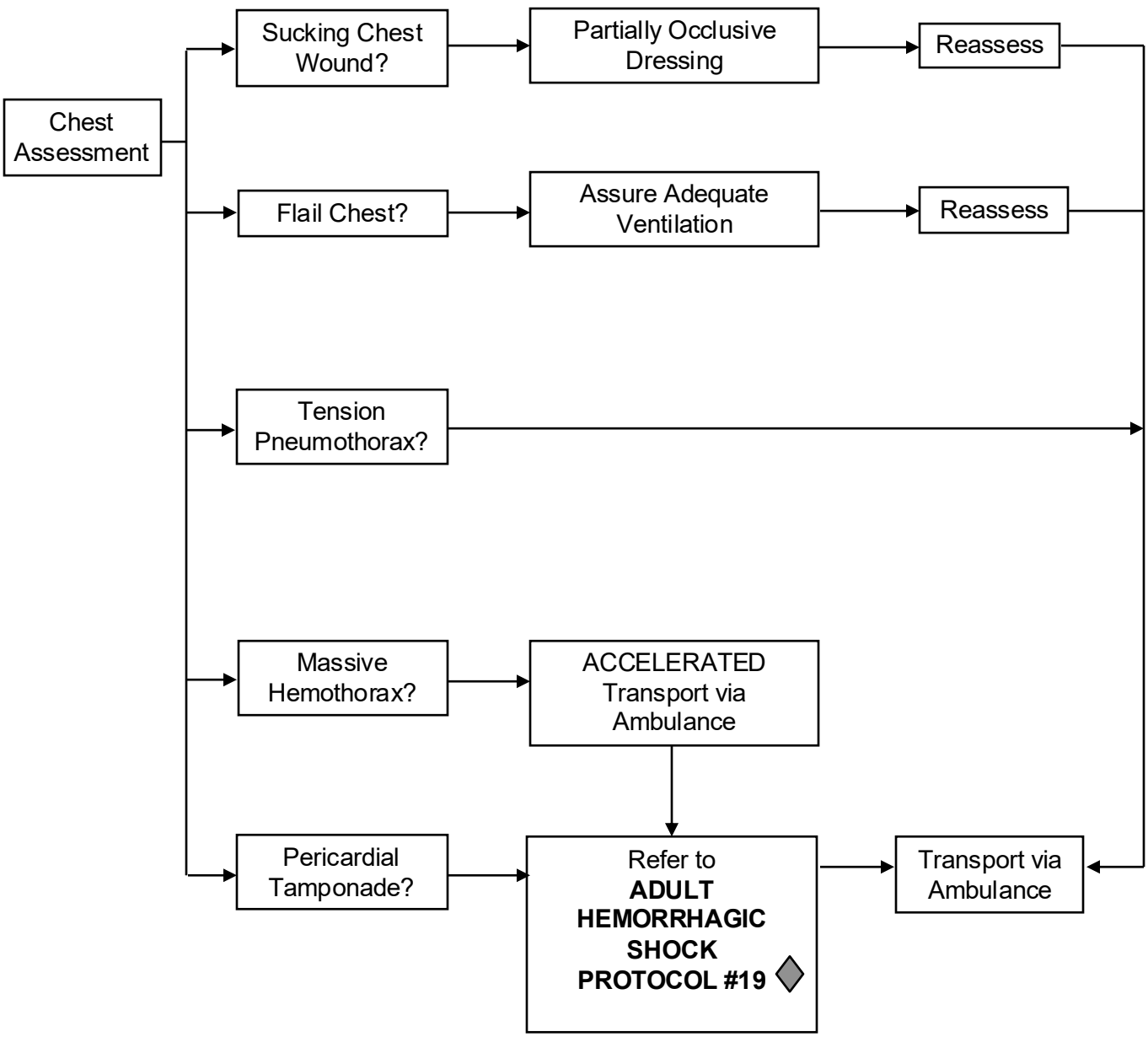
Transport via Ambulance

For a pediatric patient refer to **PEDIATRIC BURNS PROTOCOL #35** ◇

Revised 5/28/2025
EMR

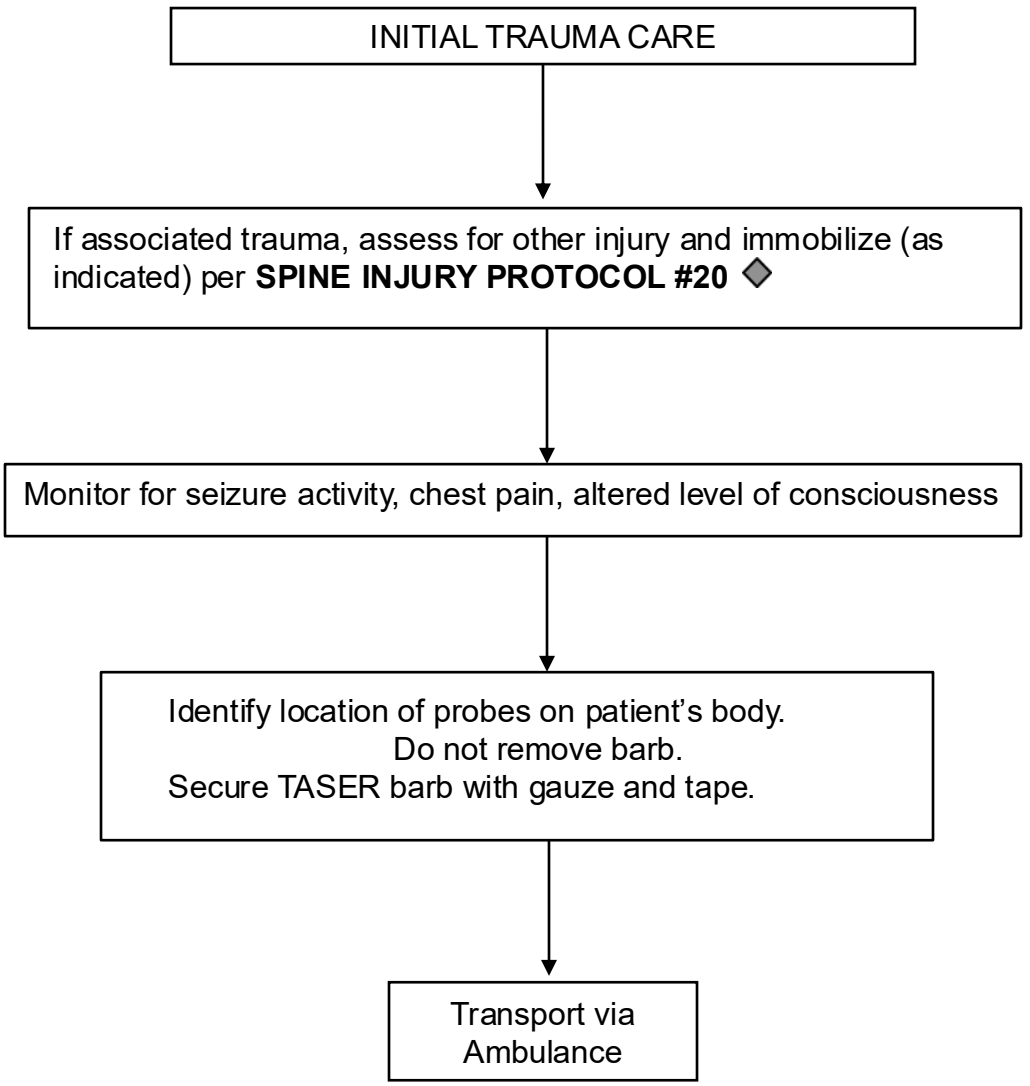
Protocol 28

CHEST TRAUMA



Protocol 29

TASER INJURY



Protocol 30

BLAST INJURIES

INITIAL TRAUMA CARE

Injury caused by multiple modalities: Burn, Blunt Penetrating Trauma, Barotrauma, Toxic Exposure:

- Identify Nature of Device: Agent/Amount. Industrial Explosion, Improvised Device, Terrorist Incident.
- Identify Method of Delivery: Incendiary, Explosive
- Nature of Environment: Open/Closed

Treat **Burns** per **ADULT BURNS PROTOCOL** #27 ◆

Treat **Crush Injury** per **ADULT CRUSH INJURY PROTOCOL** #24 ◆

Treat **Head Injury** per **HEAD TRAUMA/UNCONSCIOUS PATIENT PROTOCOL** #21 ◆

Treat **Hazardous Material Exposures** per **HAZARDOUS MATERIALS-GENERAL PROTOCOL** #45 ◆

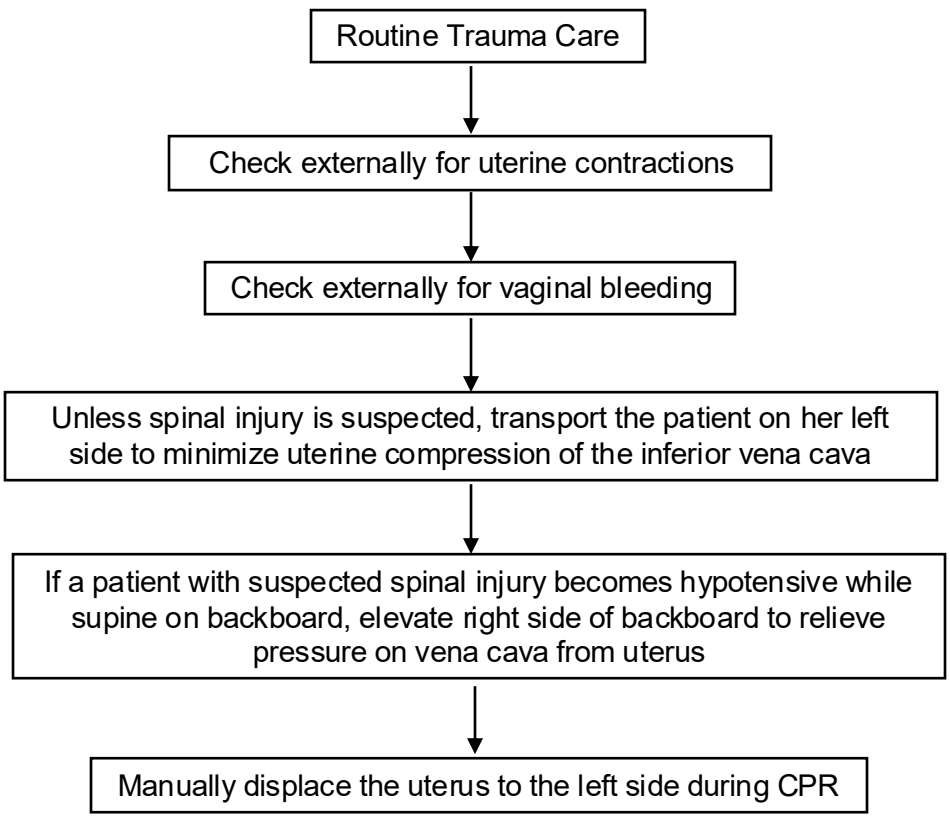
Transport via Ambulance

NOTE TO PREHOSPITAL PROVIDERS:
Note about Blast Lung Injury: Respiratory difficulty and Hypoxia more likely in enclosed space or in close proximity to explosion. Avoid hyperventilation.

Protocol 31

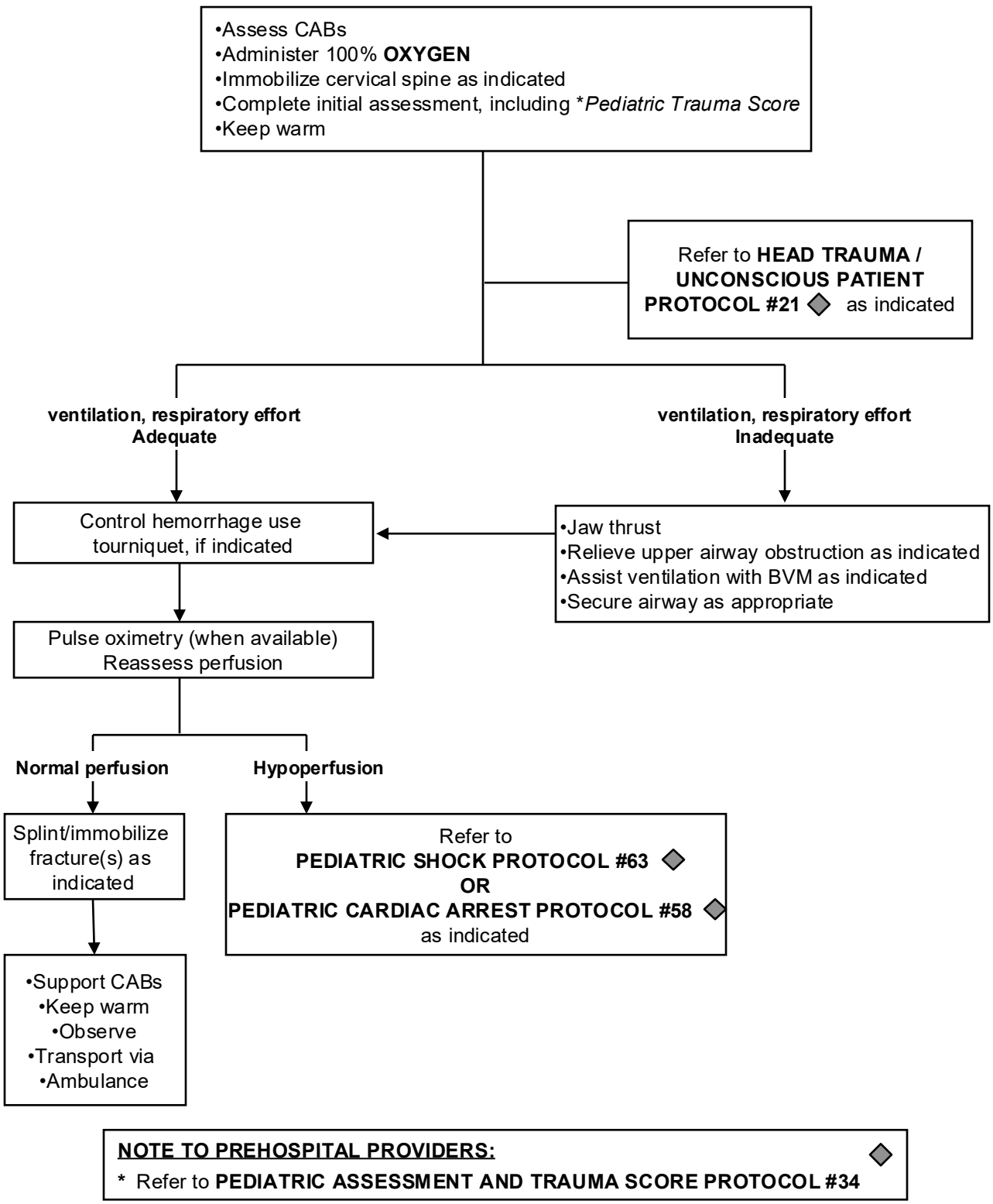
TRAUMA IN PREGNANCY

Principles of Management



Protocol 32

INITIAL MANAGEMENT OF THE PEDIATRIC TRAUMA PATIENT



NOTE TO PREHOSPITAL PROVIDERS:

* Refer to **PEDIATRIC ASSESSMENT AND TRAUMA SCORE PROTOCOL #34**

Protocol 32a

PEDIATRIC HEAD TRAUMA ADDENDUM

INITIAL MEDICAL CARE

- Maintain supine position
- Immobilize (as indicated) per SPINE INJURY PROTOCOL #20 ◆
- Assess Pediatric Glasgow Coma Scale/Glasgow Coma Scale (PGCS/GCS)
- Administer OXYGEN
- Monitor pulse oximetry

PGCS/GCS 13-15 (Mild)

- Control hemorrhage
- Reassess PGCS/GCS
- Observe
- TRANSPORT

PGCS/GCS 9-12 (Moderate)

- Support ventilation with bag mask as indicated*
- Control hemorrhage
- Reassess PGCS/GCS
- Observe
- TRANSPORT

PGCS/GCS ≤8 (Severe)

- Support ventilation with bag mask
- Control hemorrhage
- Reassess PGCS/GCS
- Observe
- TRANSPORT by ambulance
- Refer to PEDIATRIC SEIZURES PROTOCOL #65 ◆

PEDIATRIC GLASGOW COMA SCALE (PGCS)		GLASGOW COMA SCALE (GCS)	
	< 2 Years	> 2 Years	Score
EYE OPENING	Spontaneous	Spontaneous	4
	To speech	To speech	3
	To pain	To pain	2
	No response	No response	1
VERBAL RESPONSE	Coos, babbles, appropriate words	Oriented/appropriate words	5
	Irritable, cries but consolable	Confused	4
	Cries to pain, inconsolable	Inappropriate words/persistent cry	3
	Moans to pain	Incomprehensible sounds	2
	No response	No response	1
MOTOR RESPONSE	Normal spontaneous movements	Obeys commands	6
	Withdraws from touch	Localizes to pain	5
	Withdraws from pain	Withdraws from pain	4
	Abnormal flexion (decorticate)	Abnormal flexion (decorticate)	3
	Abnormal extension (decerebrate)	Abnormal extension (decerebrate)	2
	No response	No response	1
TOTAL PGCS/GCS SCORE:			(3-15)

Protocol 33

PEDIATRIC TRAUMA

Routine Trauma Care

1. Circulation
   1. Note variation of normal values

2. Airway
   - Keep suction available
   - Cervical spine immobilization

3. Breathing
   1. Note changes in ventilation rates by age
   2. 100% **OXYGEN**
   3. Assist ventilations as needed

Treatment of suspected child abuse or neglect:
(Refer to SUSPECTED CHILD ABUSE AND NEGLECT PROTOCOL #71)◆

1. Treat obvious injuries

2. If parents refuse to let you transport the child after treatment:
   1. Remain at the scene
   2. Call for police assistance
   3. Request that the officer place the child under protective custody
   4. Assist with transport

3. You are required by law to report your suspicions to the Department of Children and Family Services (DCFS). Also, document and report your suspicions to the ED physician and/or charge nurse.

4. Carefully document history, physical findings and environmental surroundings on patient care report.

Protocol 34

PEDIATRIC ASSESSMENT AND TRAUMA SCORE

Indicators of hypoperfusion:

- Respiratory difficulty
- Cyanosis despite oxygen administration
- Truncal pallor/cyanosis and coolness
- Hypotension (ominous sign)
- Bradycardia (late sign)
- Weak, thready, or absent peripheral pulses
- Decreasing consciousness
- No palpable blood pressure

Pediatric vital signs:

	Newborn	1 year	3 years	6 years	10 years	15 years
Pulse	100-160	90 - 120	80 - 120	70 - 110	60 - 90	60 - 90
Respirations	30- 60	20 - 30	20 - 30	18 - 25	15 - 20	15 - 18
Systolic BP	50- 90	80 - 100	80 - 110	80 - 110	90 - 120	100 - 130

Pediatric Trauma Score*:

Component	+2	+1	-1
Weight	>20 kg	10-20 kg	<10 kg
Airway	Normal	Maintainable	Unmaintainable
CNS	Awake	Obtunded	Coma
Systolic BP **or** ***Pulse Palpable*	>90mmHg *At Wrist*	90-50mm Hg *At Groin*	<50 mmHg or *No Pulse Palpable*
Open Wound	None	Minor	Major
Skeletal Injury	None	Closed Fx	Open/Multiple Fx

***If proper size BP cuff is unavailable, BP may alternatively be assigned by determining pulse palpable point.*

TOTAL POINTS _____

(Total points range from -6 to +12)

Protocol 35

PEDIATRIC BURNS: THERMAL, ELECTRICAL, CHEMICAL

- Assess scene safety, wear BSI, remove patient to safety
- Assess CABs
- Administer 100% **OXYGEN**
- Complete initial assessment assessing for:
  - wheezing
  - retractions
  - stridor
  - diminished respirations or apnea
  - tachypnea
  - grunting
  - decreasing consciousness
- Refer to **INITIAL MANAGEMENT OF THE PEDIATRIC TRAUMA PATIENT PROTOCOL #32** ◇
- Assess percentage/depth of burn
- Remove constricting jewelry and clothes.

ESTIMATING % OF BODY SURFACE AREA

Body Area	*Age in Years*			
	0-1	*1-4*	*4-9*	*10-15*
Head	19%	17%	13%	10%
Neck	2%	2%	2%	2%
Chest or Back (each)	13%	13%	13%	13%
Buttock (each)	2.5%	2.5%	2.5%	2.5%
Genitalia	1%	1%	1%	1%
Upper Arm (each)	4%	4%	4%	4%
Lower Arm (each)	3%	3%	3%	3%
Hand (each)	2.5%	2.5%	2.5%	2.5%
Thigh (each)	5.5%	6.5%	8.5%	8.5%
Lower leg (each)	5%	5%	5%	6%
Foot (each)	3.5%	3.5%	3.5%	3.5%

No Respiratory Compromise

Respiratory Compromise

- Support ventilation with BVM
- Secure airway as appropriate
- Refer to **PEDIATRIC RESPIRATORY DISTRESS PROTOCOL #61** ◇

Follow correct burn type path

THERMAL BURNS

Superficial (1st degree)

- Cover burn wound with dry sterile dressing.

Partial or Full thickness (2nd or 3rd degree)

- Wear sterile gloves/mask while burn areas are exposed
- Cover burn wound with DRY sterile dressings
- Place patient on clean sheet on stretcher and cover patient with dry clean sheets and blanket to maintain body temperature.

- Refer to **PEDIATRIC SHOCK PROTOCOL #63** ◇ as indicated

ELECTRICAL BURNS

- Immobilize as indicated
- Identify and document any entrance and exit wounds
- Assess neurovascular status of the affected part
- Cover wounds with dry sterile dressings

- Support CABs
- Observe
- Keep warm
- Transport via Ambulance

CHEMICAL BURNS

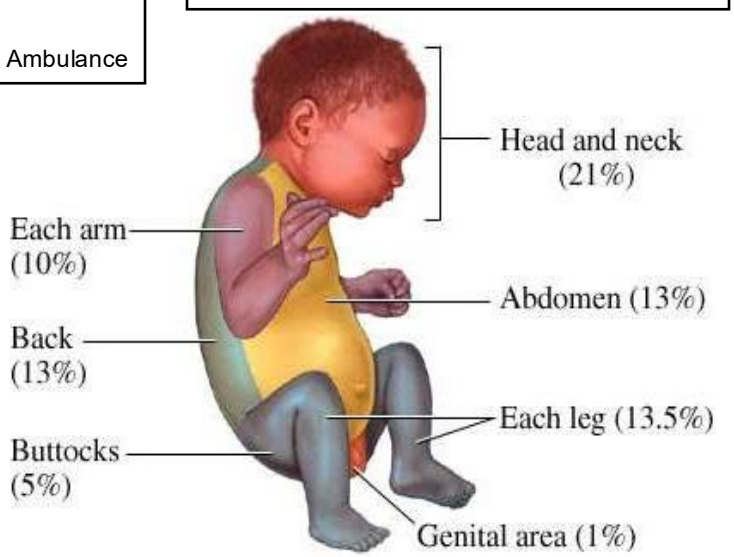
- Refer to **PEDIATRIC TOXIC EXPOSURE/ INGESTIONS PROTOCOL #67** ◇
- If powdered chemical, brush away excess
- Remove clothing if possible
- Rapid visual acuity
- If eye involvement, irrigate with saline or sterile water continuously.

DO NOT CONTAMINATE THE UNINJURED EYE WITH IRRIGATION

- Irrigate area with copious amounts of sterile water or saline ASAP and during transport

SPECIAL CONSIDERATIONS:

- Assess for potential child abuse and refer to **SUSPECTED CHILD ABUSE AND NEGLECT PROTOCOL # 71** ◇
- Keep the child warm and protect from hypothermia.
- Pulse oximetry (when available)



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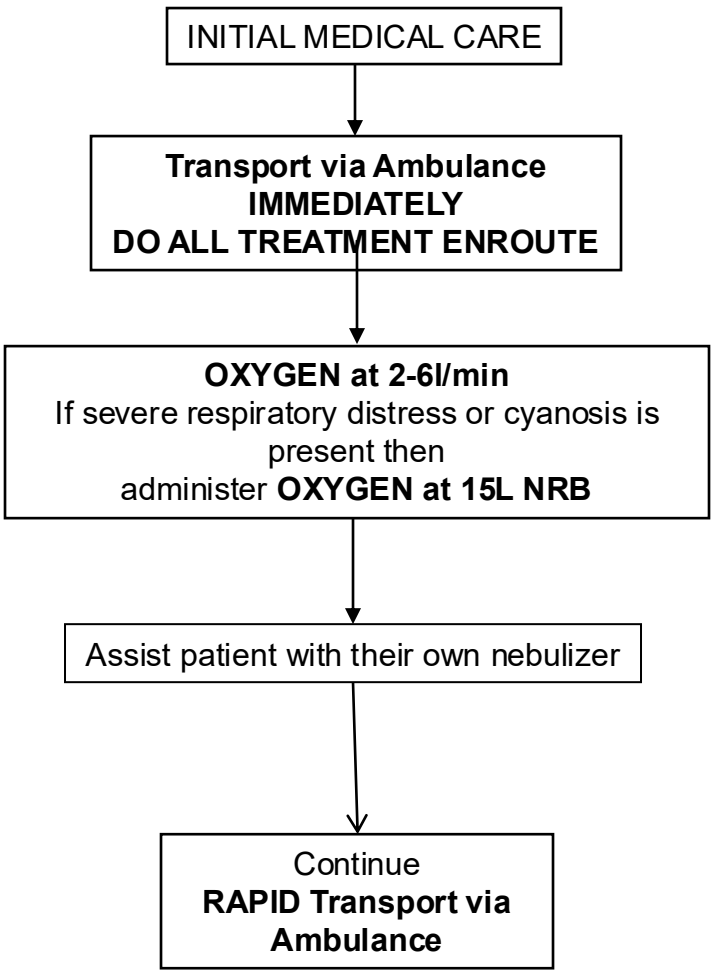
EMR

Protocol 36

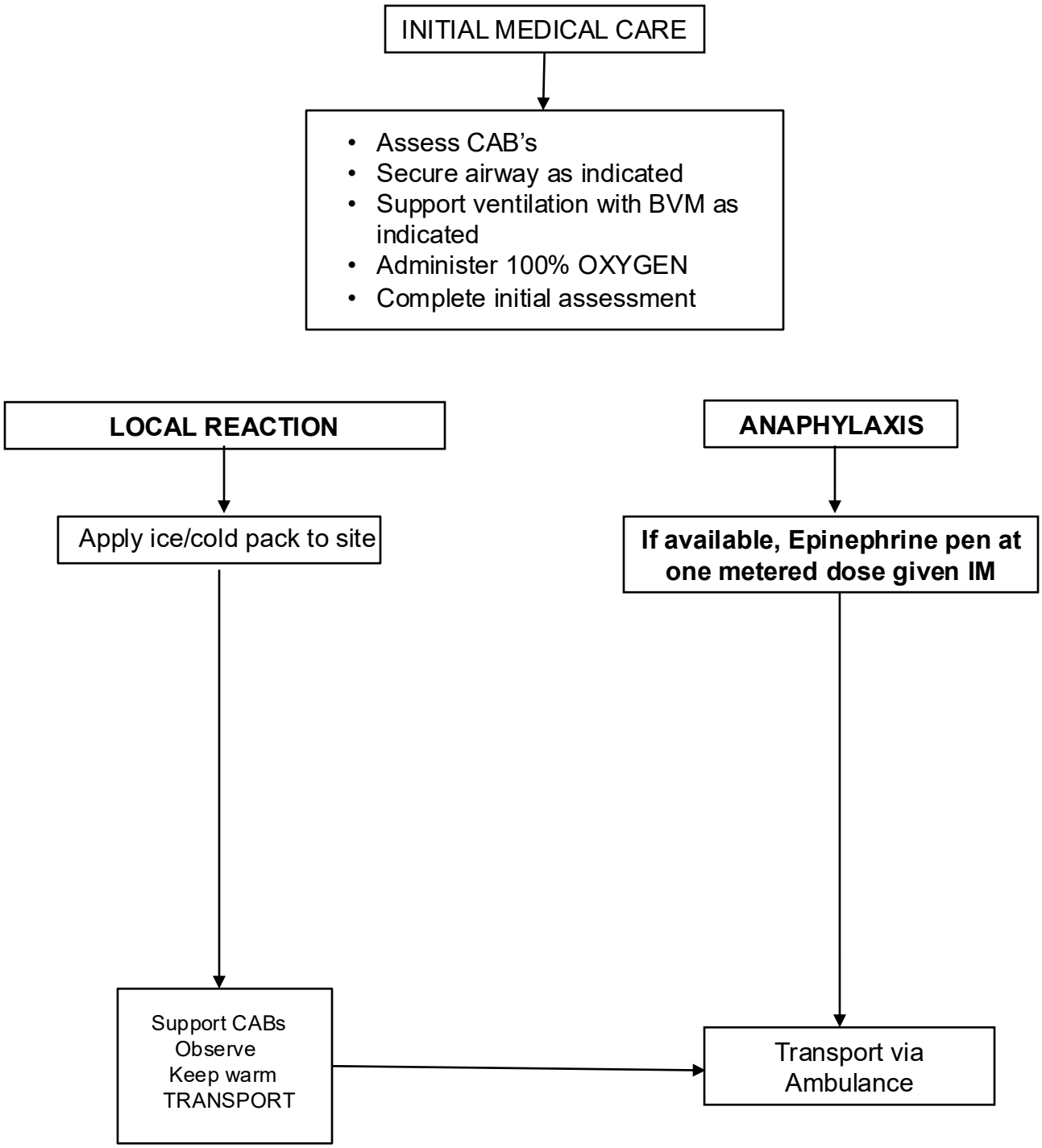
ADULT ACUTE ASTHMA/COPD WITH WHEEZING



For a pediatric patient refer to **PEDIATRIC RESPIRATORY DISTRESS PROTOCOL #61**

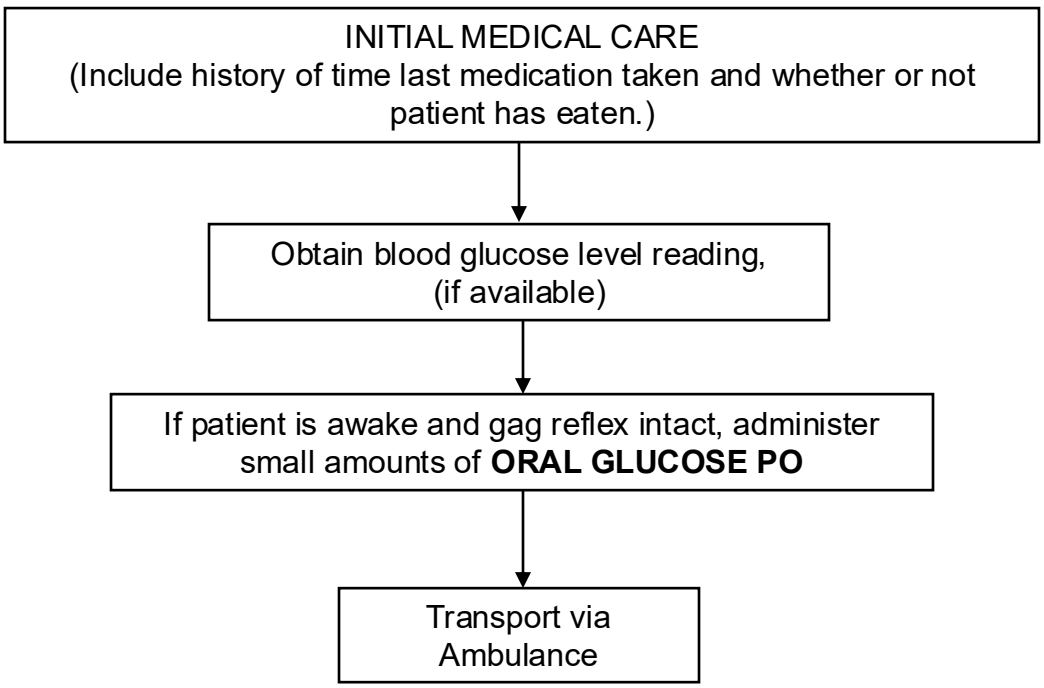
Protocol 37

ADULT ALLERGIC REACTION / ANAPHYLACTIC SHOCK



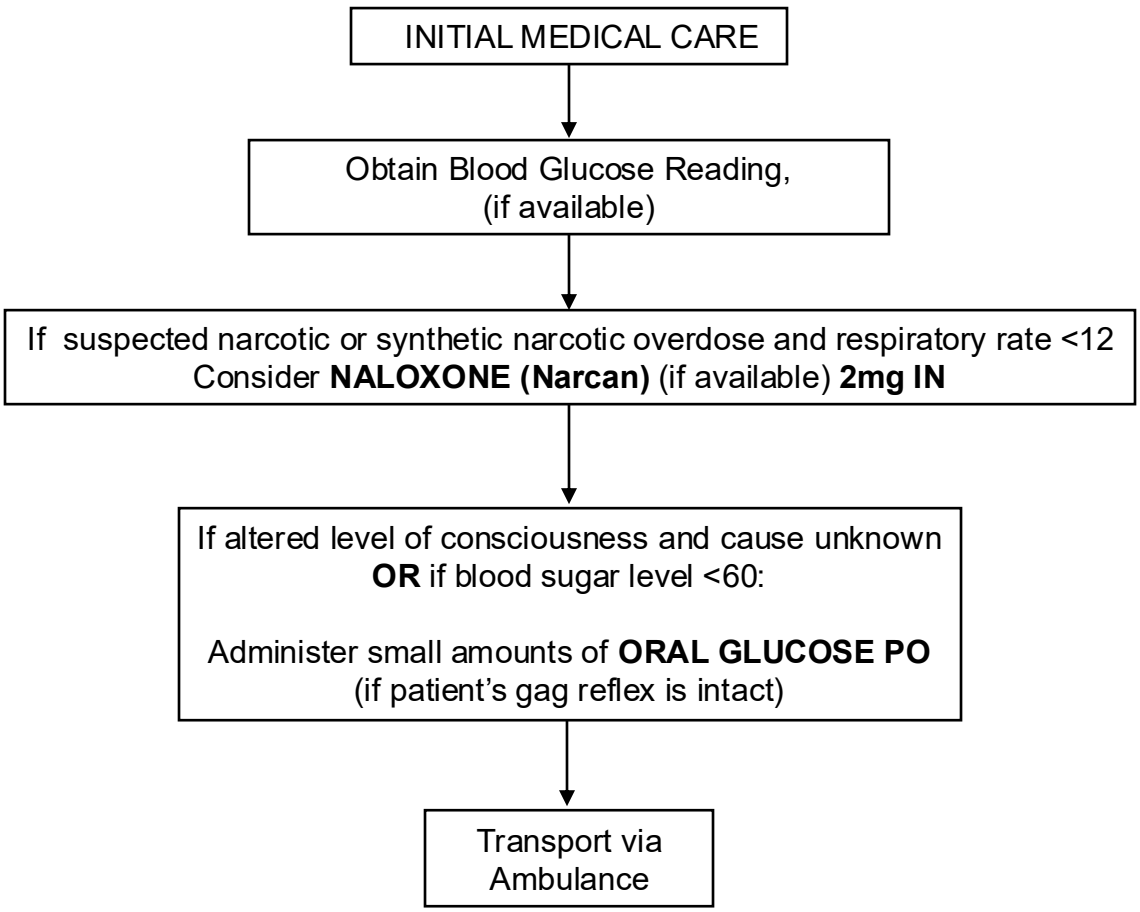
Protocol 38

ADULT DIABETIC/GLUCOSE EMERGENCIES



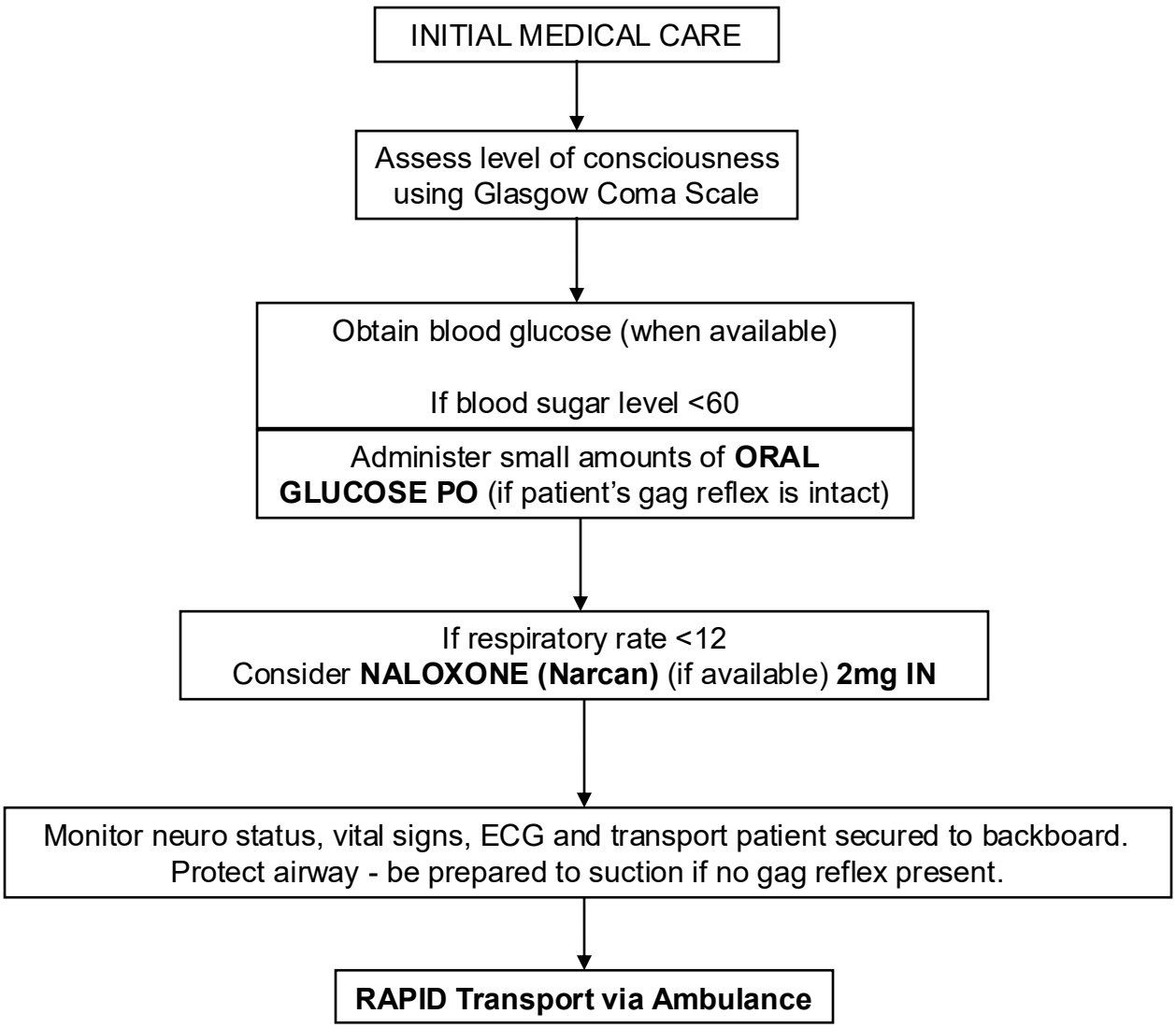
Protocol 39

ADULT DRUG OVERDOSE ALCOHOL RELATED EMERGENCIES POISONING



Protocol 40

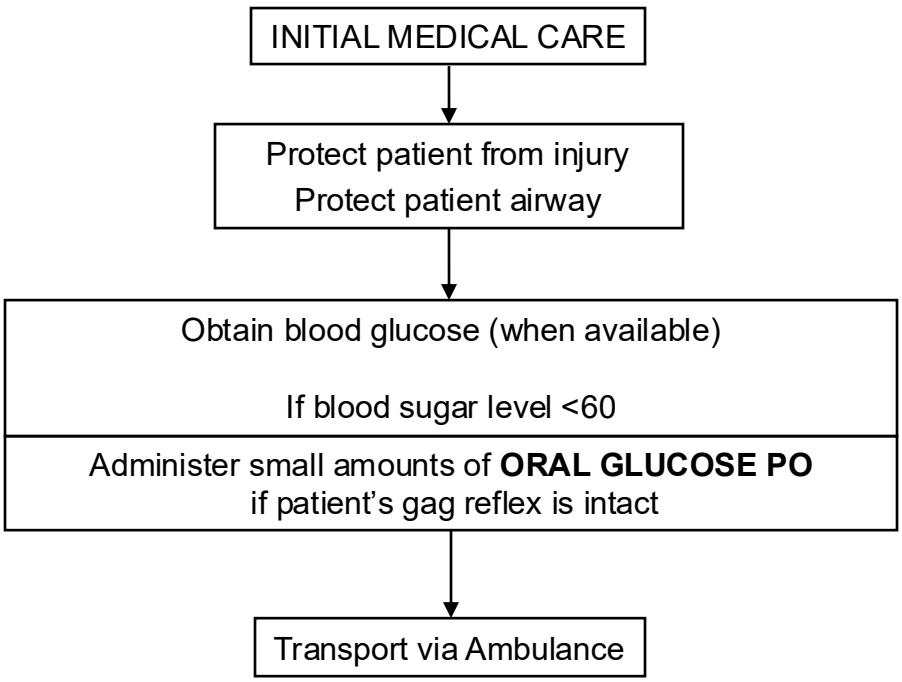
ADULT COMA OF UNKNOWN ORIGIN (NO HISTORY OF TRAUMA)



For a pediatric patient refer to **PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS PROTOCOL #66**

Protocol 41

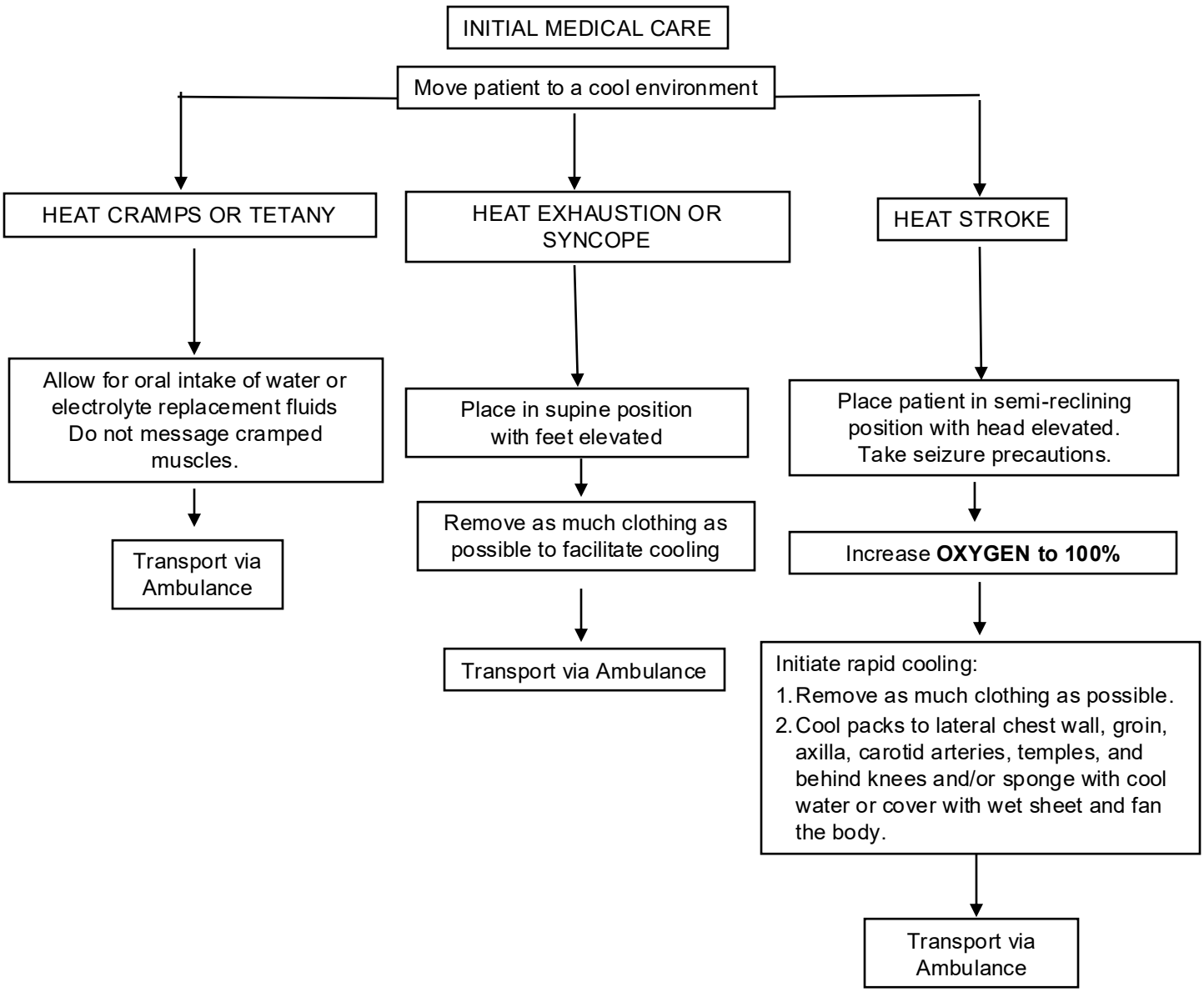
ADULT SEIZURES / STATUS EPILEPTICUS



For a pediatric patient refer to **PEDIATRIC SEIZURES PROTOCOL #65** ◇

Protocol 42

ADULT HEAT EMERGENCIES



For a pediatric patient refer to **PEDIATRIC HEAT EMERGENCIES PROTOCOL #68**

Protocol 43

ADULT COLD EMERGENCIES

Frostbite

Move patient to a warm environment as soon as possible

- Handle skin like a burn
- Protect with light sterile dressings
- Do not let skin rub on skin (between fingers or toes)

Do not forcibly remove clothes that stick to affected area.

Cover patient and prevent re-exposure.

Transport via Ambulance

Systemic Hypothermia

Mild/Moderate 93.2 - 86 F (34-30 C)
Conscious
OR
Altered sensorium with shivering

OXYGEN 12-15 L/mask

Rewarm patient:
- Place patient in a warm environment.
- Remove wet clothing.
- Apply hot packs wrapped in towels to axilla, groin, neck, thorax.
- Wrap patient in blankets.

Transport via Ambulance

Severe Hypothermia

86 F or less (<30 C):
- HANDLE PATIENT VERY GENTLY TO AVOID PRECIPITATING V-FIB.
- Patient may appear uncoordinated with poor muscle control, or stiff simulating rigor mortis.
- There will be NO SHIVERING.
- Level of consciousness may be confused, lethargic and/or withdrawn
- Coma

TRIPLE ZERO CANNOT BE CONFIRMED FROM THE FIELD ON THESE PATIENTS*

Transport via Ambulance

OXYGEN 100% enroute
Do not hyperventilate

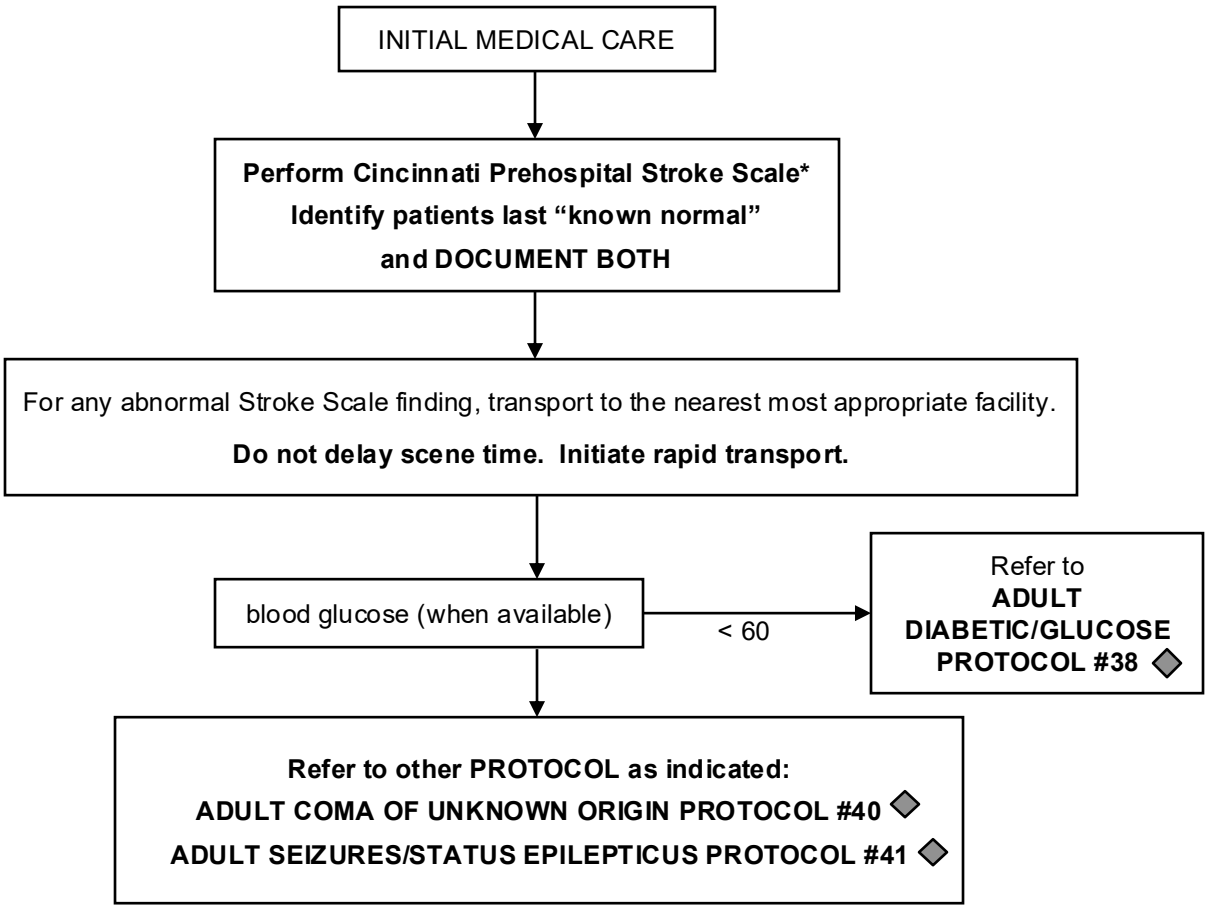
***NOTE TO PREHOSPITAL PROVIDERS:**

Assess pulse for 30-45 seconds before beginning CPR.
Begin CPR only if pulseless and not breathing.
Apply AED (if available). May attempt defibrillation x 1

For a pediatric patient refer to **PEDIATRIC COLD EMERGENCIES PROTOCOL #69** ◇

Protocol 44

ADULT SUSPECTED STROKE: PG 1 of 2



***Cincinnati Prehospital Stroke Scale**

Facial Droop (Have the patient show teeth or smile)

- •Normal – Both sides of face move equally well
- •Abnormal – One side of face does not move as well as the other side

Arm Drift (Patient closes eyes and holds both arms straight out for 10 seconds with palms up)

- •Normal – Both arms move the same or both arms do not move at all
- •Abnormal – One arm does not move or one arm drifts down compared with the other

Speech (Have the patient say, "You can't teach an old dog new tricks.")

- •Normal – Patient uses correct words with no slurring
- •Abnormal – Patient slurs words, uses inappropriate words, or is unable to speak

Protocol 44

ADULT SUSPECTED STROKE: PG 2 of 2

**Rapid Arterial Occlusion Evaluation (RACE) Scale for Large Vessel Occlusion

A STROKE ASSESSMENT TOOL FOR EMS

EMS RACE Stroke Scale - Rapid Arterial oCclusion Evaluation Scale, used to predict large cerebral arterial occlusions.*

ITEM	INSTRUCTION		RACE Score
FACIAL PALSY	Ask the patient to show their teeth	ABSENT (symmetrical movement) MILD (slightly asymmetrical) MODERATE TO SEVERE (completely asymmetrical)	0 1 2
ARM MOTOR FUNCTION	Extending the arm of the patient 90 degrees (if sitting) of 45 degrees (if supine)	NORMAL TO MILD (limb upheld more than 10 seconds) MODERATE (limb upheld less than 10 seconds) SEVERE (patient unable to raise arm against gravity)	0 1 2
LEG MOTOR FUNCTION	Extending the leg of the patient 30 degrees (if supine)	NORMAL TO MILD (limb upheld more than 5 seconds) MODERATE (limb upheld less than 5 seconds) SEVERE (patient unable to raise leg against gravity)	0 1 2
HEAD AND GAZE DEVIATION	Observe eyes and cephalic deviation to one side	ABSENT (eye movements to both sides were possible and no cephalic deviation was observed) PRESENT (eyes and cephalic deviation to one side was observed)	0 1
APHASIA If right hemiparesis	Ask the patient two verbal orders: - *"close your eyes"* - *"make a fist"*	NORMAL (performs both tasks correctly) MODERATE (performs one task correctly) SEVERE (performs neither task)	0 1 2
AGNOSIA If left hemiparesis	Asking: - *"Who's arm is this?" while showing him/her the paretic arm (asomatognosia)* - *"Can you move your arm?" (anosognosia)*	NORMAL (no asomatognosia nor anosognosia) MODERATE (asomatognosia or anosognosia) SEVERE (both asomatognosia and anosognosia)	0 1 2
		RACE SCALE TOTAL: Any score above a "0" is a "Stroke Alert"	

* Chart adapted from Perez de la Ossa N, Carrera D, Gorchs M, et al. Design and validation of a prehospital stroke scale to predict large arterial occlusion: the rapid arterial occlusion evaluation scale. Stroke; a journal of cerebral circulation. Jan 2014;45(1):87-91.

MEDICAL

Protocol 45

HAZARDOUS MATERIALS GENERAL

CHEMTREC
(800) 262-8200

PROTECT YOURSELF FIRST:
ALL PERSONNEL SHOULD BE APPROPRIATELY TRAINED AND HAVE PROTECTIVE CLOTHING AS INDICATED

↓

Identify substance, if possible contact local HazMat unit*

↓

Isolate

↓

Brush off solid substances, remove contaminated clothing and decontaminate as indicated
The decontaminate should be contained if possible.

↓

Maintain Airway. Administer **OXYGEN 12-15L/min**. by mask.
Assist ventilations with BVM, if indicated, using 100% **OXYGEN**.

↓

Treat per appropriate protocol: ◇
SHOCK
CARDIAC DYSRHYTHMIAS
PULMONARY EDEMA
SEIZURES
BURNS (CHEMICAL)
UNCONSCIOUSNESS
ASTHMA/COPD WITH WHEEZING
FROSTBITE

↓

Refer to **HAZARDOUS MATERIALS EYE PROTOCOL #46** ◇ for eye exposures

↓

Treat specific poisons with antidotes per **Medical Control**

↓

Transport via Ambulance

NOTE TO PREHOSPITAL PROVIDERS:

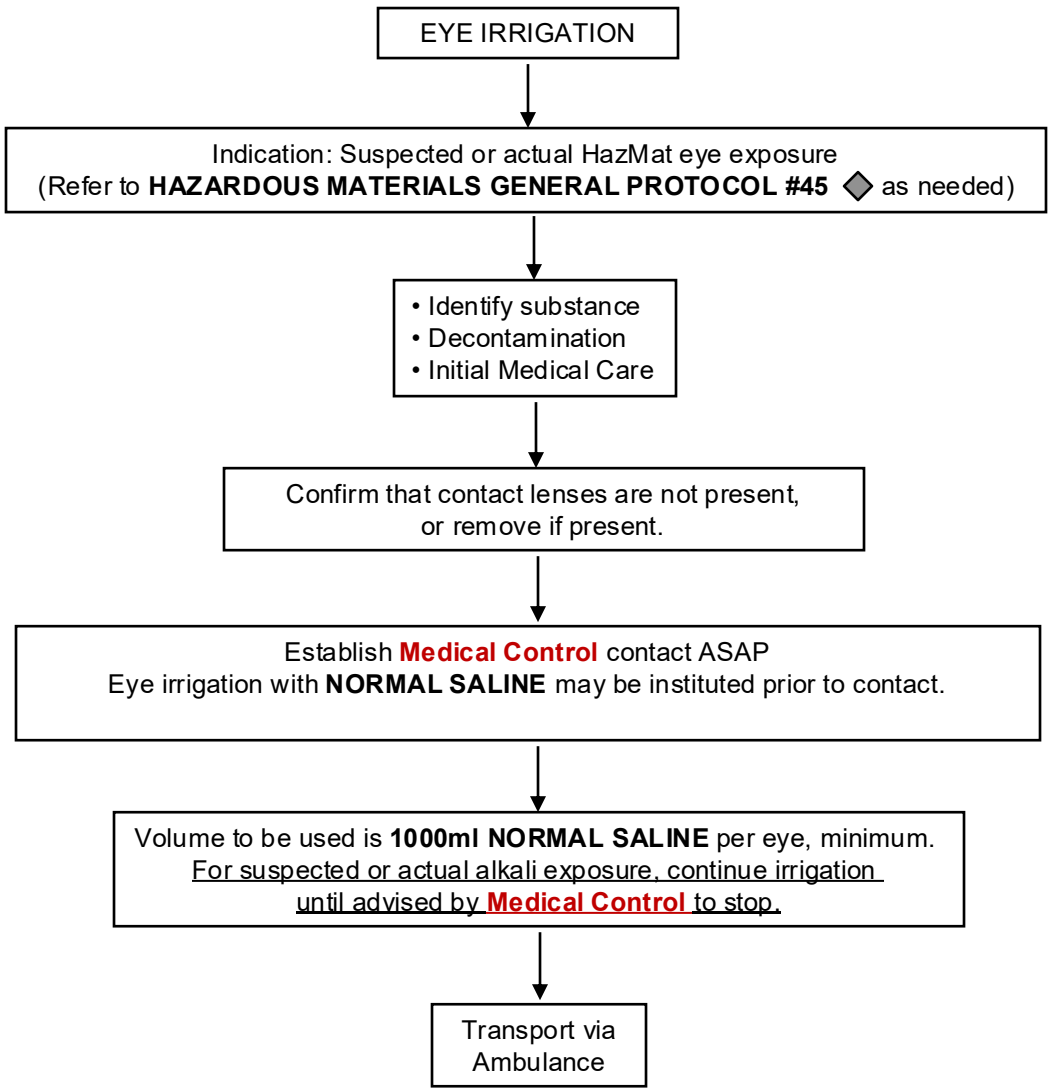
*Consult Hazardous Materials Injuries, A Handbook for Prehospital Care,

The North American ERG, MSDS sheet or similar text.

Revised 5/28/2025
EMR

Protocol 46

HAZARDOUS MATERIALS EYE

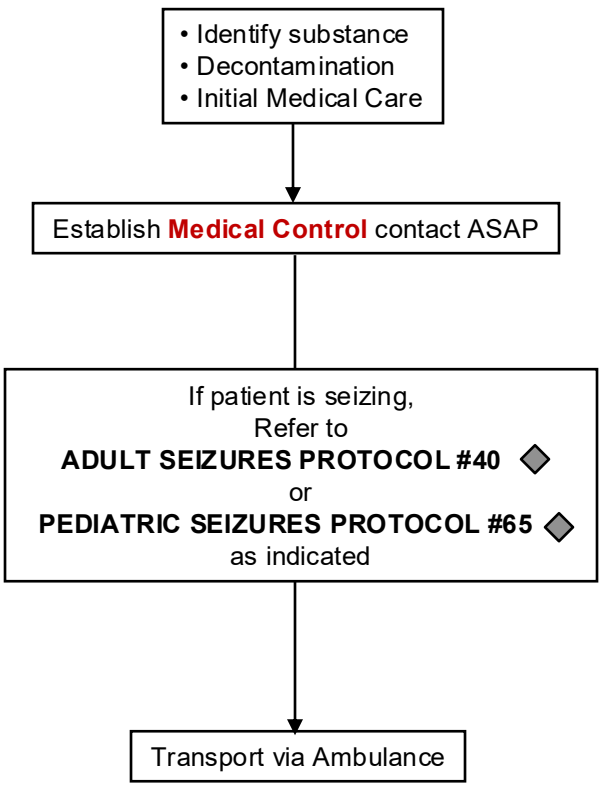


Protocol 47

HAZARDOUS MATERIALS PESTICIDE / NERVE AGENT

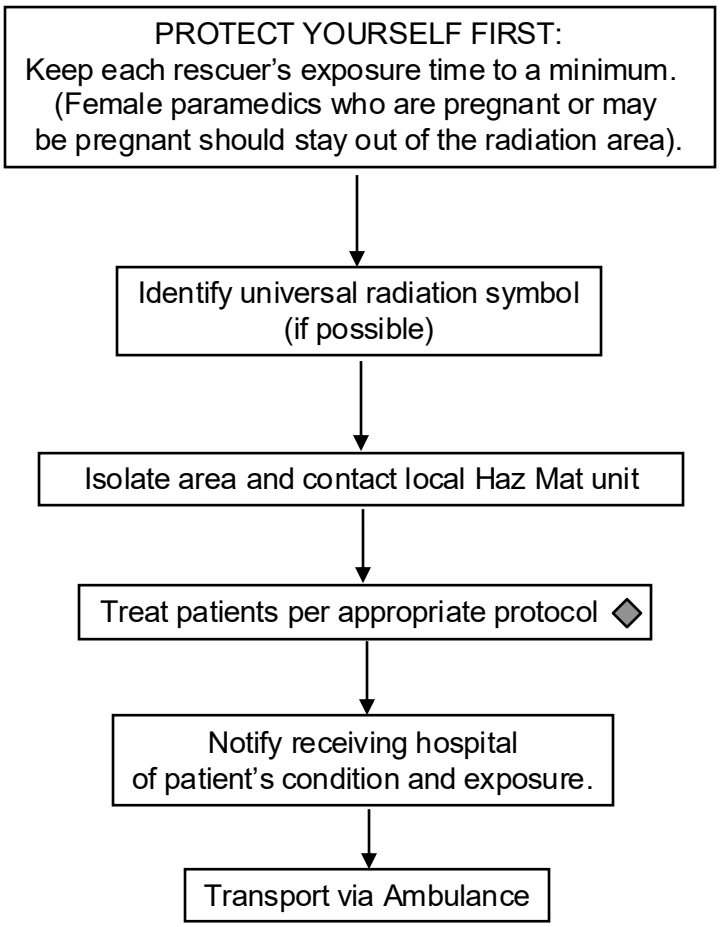
Indications: Poisoning with anticholinesterase agents (e.g., chemicals or pesticides of the organophosphate class)

Signs & Symptoms:
Bradycardia leading to heart block
Chest tightness and wheezing due to bronchospasm
Increased salivation, sweating and tearing
Increased urination
Abdominal cramps with nausea and vomiting
Constricted pupils
Weakness, muscle tremors/twitching/cramps
Seizures, coma, shock, respiratory arrest



Protocol 48

HAZARDOUS MATERIALS RADIATION



Protocol 49

ADULT
HAZARDOUS MATERIALS
TOXIC/SMOKE INHALATION
CYANIDE POISONING

PROTECT YOURSELF AND OTHER PROVIDERS FIRST

↓

Maintain patent airway and assess CAB's often

↓

INITIAL MEDICAL CARE

↓

PATIENT PRESENTING WITH:

- Altered mental status/Coma
- Headache/Confusion/Disorientation
- Dyspnea/Chest tightness/Nausea/Emesis
- Pupil dilation/Seizure
- Abnormal vital signs

↓

Apply **OXYGEN 10-15 L/min** by NRM

↓

Continual patient assessment

↓

Transport and contact **Medical Control** as soon as possible

*Remember Pulse Ox can be incorrect in cases of increased carboxyhemoglobin.
Do not rely on SpO2 for guidance of patient care.
Apply Rad57 (if available) for CO level and provide **OXYGEN 10-15 L/minute** to any patient with respiratory symptoms.

Protocol 50

ADULT SUSPECTED SEPSIS

INITIAL MEDICAL CARE

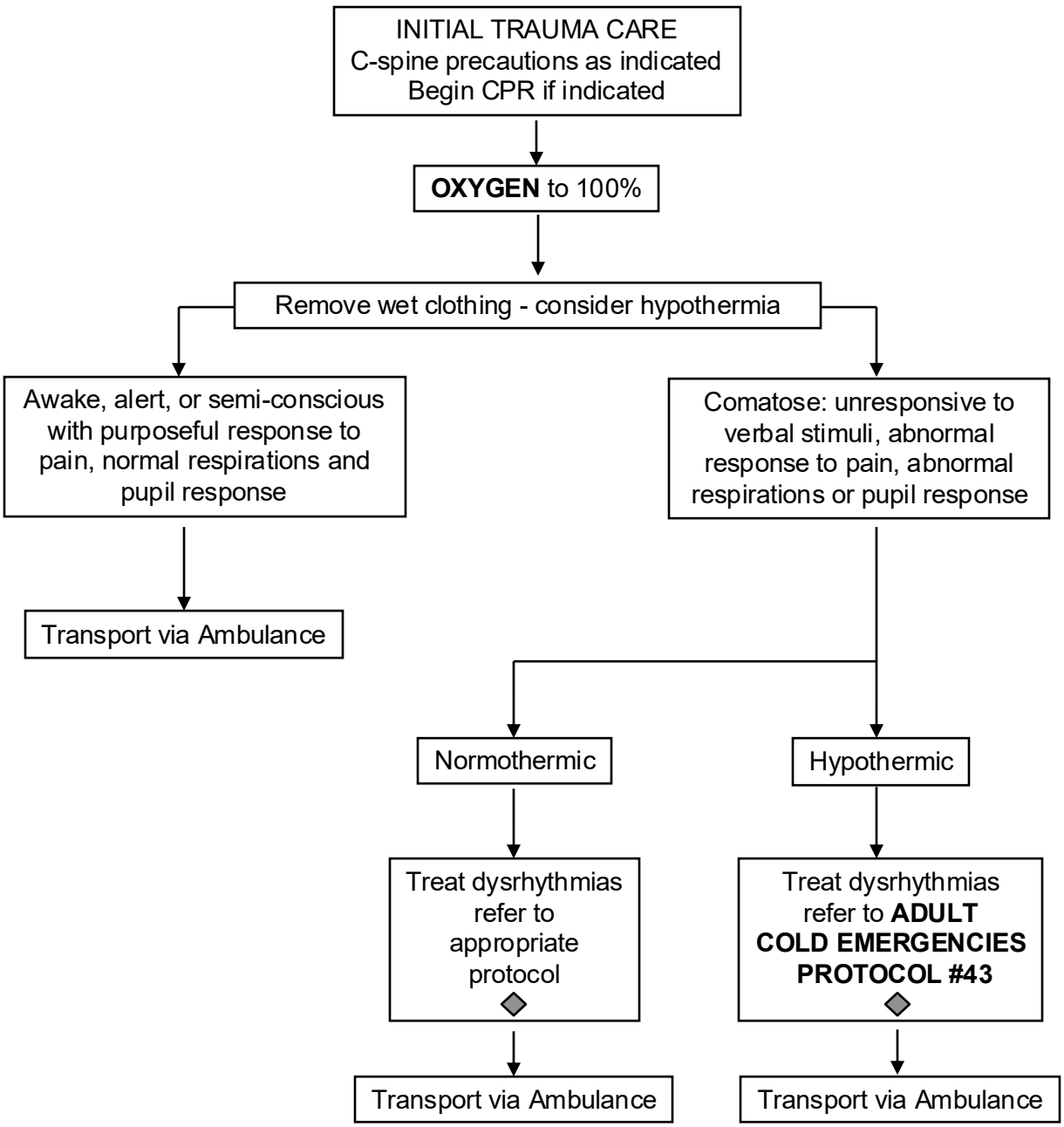
HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL
•Duration and severity of fever •Past medical history •Medications / recent antibiotics •Immunocompromised (transplant, HIV, diabetes, cancer) •Indwelling medical device •Last acetaminophen or ibuprofen •Recent hospital / healthcare facility •Bedridden or immobile •Elderly and very young-at risk •Prosthetic device / indwelling device	•Warm •Flushed •Sweaty •Chills/rigors •Delayed cap refill Mental status changes **ASSOCIATED SYMPTOMS (helpful to localize source)** •Myalgia, cough, chest pain, headache, dysuria, abdominal pain, rash	•Infections: UTI, Pneumonia, Skin/wound •Cancer / Tumors / Lymphomas •Medication or drug reaction •Connective tissue disease: Arthritis, Vasculitis •Hyperthyroidism •Heat Stroke •Meningitis •Hypoglycemia / hypothermia •MI/CVA

SEPSIS SCREEN:	Pediatrics SIRS Criteria
Obvious or suspected source of infection AND any of these SIRS (Systemic Inflammatory Response Syndrome) criteria: •SBP < 90 mmHg •Heart Rate > 90/minute •Respiratory Rate > 20 •GCS < 15 •Temperature ≥ 100.4°F or < 96.0°F	**Temperature** Same as adult AND **Heart Rate** 1month – 1 year > 180 2 – 5 years > 140 6 – 12 years > 130 13 – 18 years > 120

Transport via Ambulance

Protocol 51

ADULT DROWNING



NOTE TO PREHOSPITAL PROVIDERS:

After 90 minutes of documented submersion time, the receiving hospital should be contacted for concurrence of no resuscitative efforts on recovery of the patient.

The Dive Team will at this time go from rescue to recovery mode.

For a pediatric patient refer to **PEDIATRIC DROWNING PROTOCOL #70** ◇

Protocol 52

EMERGENCY CHILDBIRTH LABOR AND DELIVERY

Obtain history and determine if there is adequate time to transport.
- # of pregnancies
- # of live births
- Due date
- How far apart are contractions
- Duration of contractions
- Length of previous labors - in hours
- Bag of water intact or time since membrane rupture
- High risk concerns - Drug use, multiple births, amniotic fluid color

↓

If mother is hyperventilating encourage slow deep breaths.
Administer **OXYGEN 12-15L/mask**

↓

PREPARE FOR DELIVERY IF bulging perineum or crowning IS PRESENT

↓

DO NOT ATTEMPT TO RESTRAIN OR DELAY DELIVERY

↓

Place mother in a supine position, put on sterile gloves, open OB pack and drape mother's abdomen and perineum.

↓

Delivery

← Cord around neck

→ Normal presentation

Cord around neck ↓

If unable to loosen and remove cord from around infant's neck, clamp x2 and cut between clamps. →

Normal presentation ↓

- Control delivery of head so it does not emerge too quickly.
- Support infant's head as it emerges and protect perineum with gentle hand pressure.
- Tear amniotic membrane if it is still intact and visible outside vagina. When infant's head delivered, suction and maintain airway.
- As shoulders emerge, guide head and neck downward to deliver anterior shoulder.
- Support and lift head and neck slightly to deliver posterior shoulder. Remainder of infant's delivery should occur with passive participation.
- Maintain a firm hold on the baby.
- Refer to **RESUSCITATION AND CARE OF THE NEWBORN PROTOCOL #55** ◇

↓

Wrap in blanket and position on side or back with constant airway monitoring

↓

Administer post-partum care - Refer to **MATERNAL CARE PROTOCOL #56** ◇

↓

Transport via Ambulance

Revised 5/28/2025
EMR

Protocol 53

OBSTETRICAL COMPLICATIONS

THIRD TRIMESTER BLEEDING - 6-9 MONTHS (Placenta Previa, Abruptio Placenta, Trauma)

- **Transport via Ambulance IMMEDIATELY**
- 100% **OXYGEN,** place mother on LEFT side
- Note type and amount of bleeding and/or discharge. Do NOT place gloved hand in vagina to check for bleeding. Palpate uterus externally for tonicity
- **Transport via Ambulance**

PRE-ECLAMPSIA OR TOXEMIA

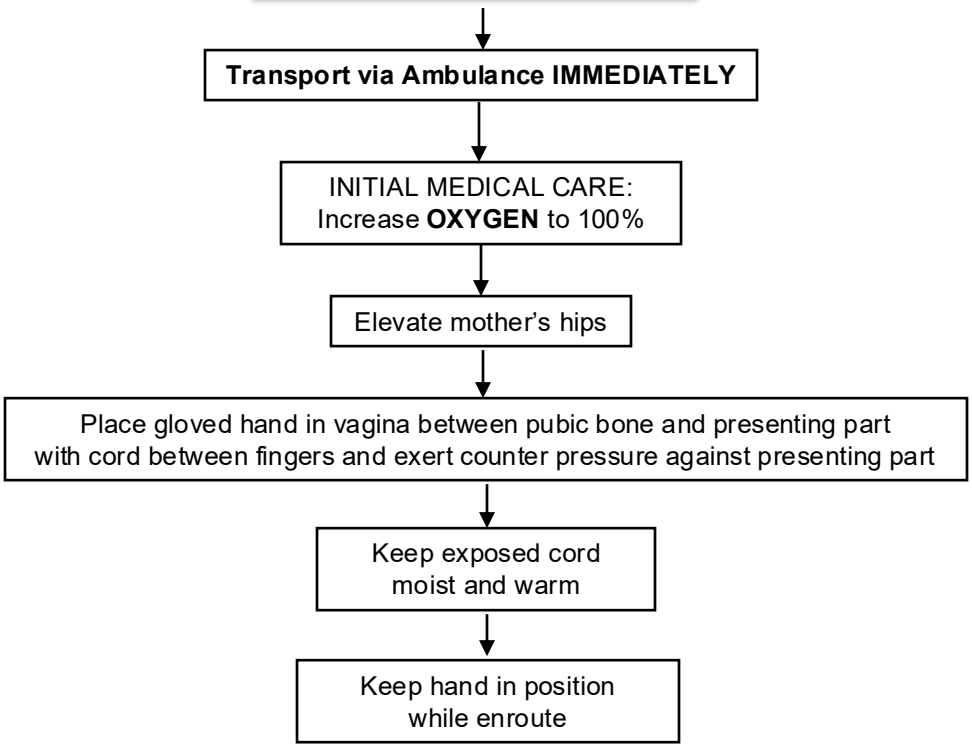
- **Transport via Ambulance IMMEDIATELY**
- **OXYGEN 12-15 L/mask**
- INITIAL MEDICAL CARE: Gentle handling
- Place mother on LEFT side
- Minimal CNS stimulation - do not check pupillary light reflex
- Seizure precautions
- If seizures occur: Increase **OXYGEN** to 100% and Refer to **ADULT SEIZURES/STATUS EPILEPTICUS PROTOCOL #41** ◈

Revised 5/28/2025
EMR

Protocol 54

ABNORMAL DELIVERIES

PROLAPSED CORD



BREECH BIRTH

1. Accelerated transport indicated with care enroute.
2. NEVER ATTEMPT TO PULL THE BABY FROM THE VAGINA BY THE LEGS OR TRUNK.
3. As soon as legs are delivered, support baby's body, wrapped in towel.
4. After shoulders are delivered, gently elevate trunk and legs to aid in delivery of head (if face down).
5. Head should deliver in 30 seconds. IF NOT, reach two gloved fingers into the vagina to locate infant's mouth.
6. Press vaginal wall away from baby's mouth to form an airway and apply gentle pressure to mother's mid-upper abdomen.
7. Maintain this position until delivery or arrival at the hospital.

Protocol 55

RESUSCITATION AND CARE OF THE NEWBORN

Initiate Medical Care/Assessment
(Begin infant prehospital care report form)

- Deliver head and body
- Term gestation? Good tone? Breathing or Crying?

YES →
- Place newborn on mom's belly for skin to skin contact
- After 30-60 seconds clamp and cut cord
- Warm, dry, stimulate
- Position airway
- Suction if needed

NO

- Clamp /cut cord
- Warm, dry, stimulate
- Position airway, suction as needed with bulb syringe (Suction mouth before nose)

Apnea or gasping
HR < 100 bpm

NO → Labored breathing or persistent cyanosis?

YES →
- Position airway, suction if needed
- Pulse Oximeter
- Oxygen if needed, 5-10 L

- Initiate bag-mask ventilation on room air for 30 seconds at rate of 40-60
- Pulse Oximeter
- Consider cardiac monitor

HR < 100 bpm?

No →

- Ensure adequate ventilation; reposition airway

HR < 60 bpm?

No →

- Administer chest compressions ratio of 3:1 compressions to ventilations
- Ventilate with 100% oxygen

- Support CABs
- Observe
- Keep warm

Place ID tags on mother and infant.

Transport via Ambulance

NOTE TO PREHOSPITAL PROVIDERS:
- Focus should be on neonate appearance (tone, breathing, crying
- Consider APGAR at 1 minute, repeat every 5 minutes
- Do not interrupt resuscitation efforts to obtain APGAR.

Apgar Score (evaluate at 1 AND 5 minutes postpartum)			
SIGN	**0**	**1**	**2**
Appearance (Skin Color)	**Blue, pale**	**Body pink extremities blue**	**Completely Pink**
Pulse rate (HR)	**Absent**	**Below 100**	**Above 100**
Grimace	**No Response**	**Grimaces**	**Cries**
Activity	**Limp**	**Some flexion of extremities**	**Active Motion**
Respiratory (Effort)	**Absent**	**Slow and Irregular**	**Strong Cry**

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Protocol 56

MATERNAL CARE

Transport via Ambulance IMMEDIATELY

↓

Allow the placenta to deliver on its own, but **DO NOT** delay transport waiting for it.
(It should deliver within 20 - 30 minutes.)
DO NOT pull on cord to facilitate delivery. If delivered, collect placenta in a plastic bag and bring to hospital.

↓

If the perineum is torn and bleeding, apply direct pressure with a sterile dressing or sanitary pad.

↓

Observe for profuse bleeding (>500ml). If present, massage uterus

↓

Mother may be encouraged to breastfeed to stimulate uterine contraction.

Protocol 57

PEDIATRIC INITIAL ASSESSMENT: PG 1 OF 3

1. SCENE SIZE UP

- Identify possible hazards.
- Assure safety for patient and responder.
- Observe for mechanism of injury/nature of illness.
- Note anything suspicious at the scene, i.e., medications, household chemicals, other ill family members.
- Assess any discrepancies between the history and the patient presentation, i.e. infant fell on hardwood floor - however floor is carpeted.
- Initiate appropriate body substance isolation (BSI) precautions
- Determination of number of patients.

2. GENERAL APPROACH TO THE STABLE/CONSCIOUS PEDIATRIC PATIENT

Assessments and interventions must be tailored to each child in terms of age, size and development.

- Smile if appropriate to the situation.
- Keep voice at even quiet tone, don't yell.
- Speak slowly, use simple, age appropriate terms.
- Use toys or penlight as distracters; make a game of assessment.
- Keep small children with their caregiver(s);
- Kneel down to the level of the child if possible.
- Be cautious in use of touch. In the stable child, make as many observations as possible before touching (and potentially upsetting) the child.
- Adolescents may need to be interviewed without Their caregivers present if accurate information is to be obtained regarding drug use, alcohol use, last menstrual period, sexual activity, child abuse.

While walking up to the patient, observe/inspect the following:

- General appearance, age appropriate behavior.
- Malnourished appearance? Is child looking around, responding with curiosity or fear, playing, sucking on a pacifier or bottle, quiet, eyes open but not moving much or uninterested in environment?
- Obvious respiratory distress or extreme pain.
- Position of the child. Are the head, neck or arms being held in a position suggestive of spinal injury? Is the patient sitting up or in tripod position?
- Level of consciousness, i.e., awake vs asleep or unresponsive.
- Muscle tone: good vs limp.
- Movement: spontaneous, purposeful, symmetrical.
- Color: pink, pale, flushed, cyanotic, mottled.
- Obvious injuries, bleeding, bruising, impaled objects or gross deformities.
- Determine weight - Use length/weight tape to determine kilos for medication administration.
- A length/weight based tape will be utilized to determine medication dosing.

3. INITIAL ASSESSMENT

Circulation

- Heart rate - compare to normal rate for age and situation.
- Central/truncal pulses (brachial, femoral, carotid) - strong, weak or absent.
- Distal/peripheral pulses - present/absent, thready, weak, strong.
- Color - pink, pale, flushed cyanotic, mottled.
- Skin temperature - hot, warm, cool.
- Blood pressure - compare to normal for age of child. Must use appropriate sized cuff.
- Hydration - anterior fontanel in infants, mucous membranes, skin turgor, crying tears, urine output history.

Protocol 57

PEDIATRIC INITIAL ASSESSMENT: PG 2 OF 3

Airway Access/Maintenance with Cervical Spine Control
- Maintainable with assistance: positioning.
- Maintainable with adjuncts: oral airway, nasal airway.
- Maintainable with endotracheal tube.
- Listen for any audible airway noises, i.e., stridor, snoring, gurgling, wheezing.
- Patency: suction secretions as necessary.

Breathing
- Rate and rhythm of respirations. Compare to normal rate for age and situation.
- Chest expansion - symmetrical.
- Breath sounds - compare both sides and listen for sounds (present, absent, normal, abnormal).
- Positioning - sniffing position, tripod positions.
- Work of breathing - retractions, nasal flaring, accessory muscle use, head bobbing, grunting.

Disability - Brief Neuro Examination
- Assess Responsiveness
  - A Alert
  - V Responds to verbal stimuli
  - P Responds to pressure
  - U Unresponsive
- Assess pupils
- Assess for transient numbness/tingling.

Expose and Examine
- Expose the patient as appropriate based on age and severity of illness.
- Initiate measures to prevent heat loss and keep the child from becoming hypothermic.

4. FOCUSED HISTORY/PHYSICAL ASSESSMENT

Tailor assessment to the needs of the patient. Rapidly examine areas specific to the chief complaint.
- Signs & Symptoms as they relate to the chief complaint.
- Allergies to medications, foods, environmental
- Medications: prescribed, over-the-counter, compliance with prescribed dosing regimen, time, date and amount of last dose
- Past Pertinent Medical History
  - Pertinent medical or surgical problems
  - Preexisting diseases/chronic illness
  - Previous hospitalizations
  - Currently under medical care
  - For infants, obtain a neonatal history (gestation, prematurity, congenital anomalies, was infant discharged home at the same time as the mother)
- Last oral intake of liquid/food ingested.
- Events surrounding current problem
  - Onset, duration and precipitating factors
  - Associated factors such as toxic inhalants, drugs, alcohol
  - Injury scenario and mechanism of injury
  - Treatment given by caregiver

Responsive Medical Patients
- Perform rapid assessment based on chief complaint. A full review of systems may not be necessary. If chief complaint is vague, examine all systems.

Protocol 57

PEDIATRIC INITIAL ASSESSMENT: PG 3 OF 3

Unresponsive Medical Patients
- Perform rapid assessment: CABs, quick head-to-toe exam.
- Emergency care based on signs and symptoms, initial impressions and standard operating procedures.

Trauma patient with NO significant mechanism of injury.
- Focused assessment is based on patient complaint.

Trauma patient WITH significant mechanism of injury.
- Perform rapid assessment of all body systems.

5. DETAILED ASSESSMENT

Performed to detect non-life-threatening conditions and to provide care for those conditions/injuries. Usually performed enroute. May be performed on scene if transport is delayed.
- Inspect and palpate each of the major body systems for the following:
- Deformities
- Contusions
- Abrasions
- Penetrations/punctures
- Burns
- Tenderness
- Lacerations
- Swelling/edema
- Instability
- Crepitus
- Auscultation of breath and heart sounds as well as blood pressure readings may be required in the field.

6. ONGOING ASSESSMENT

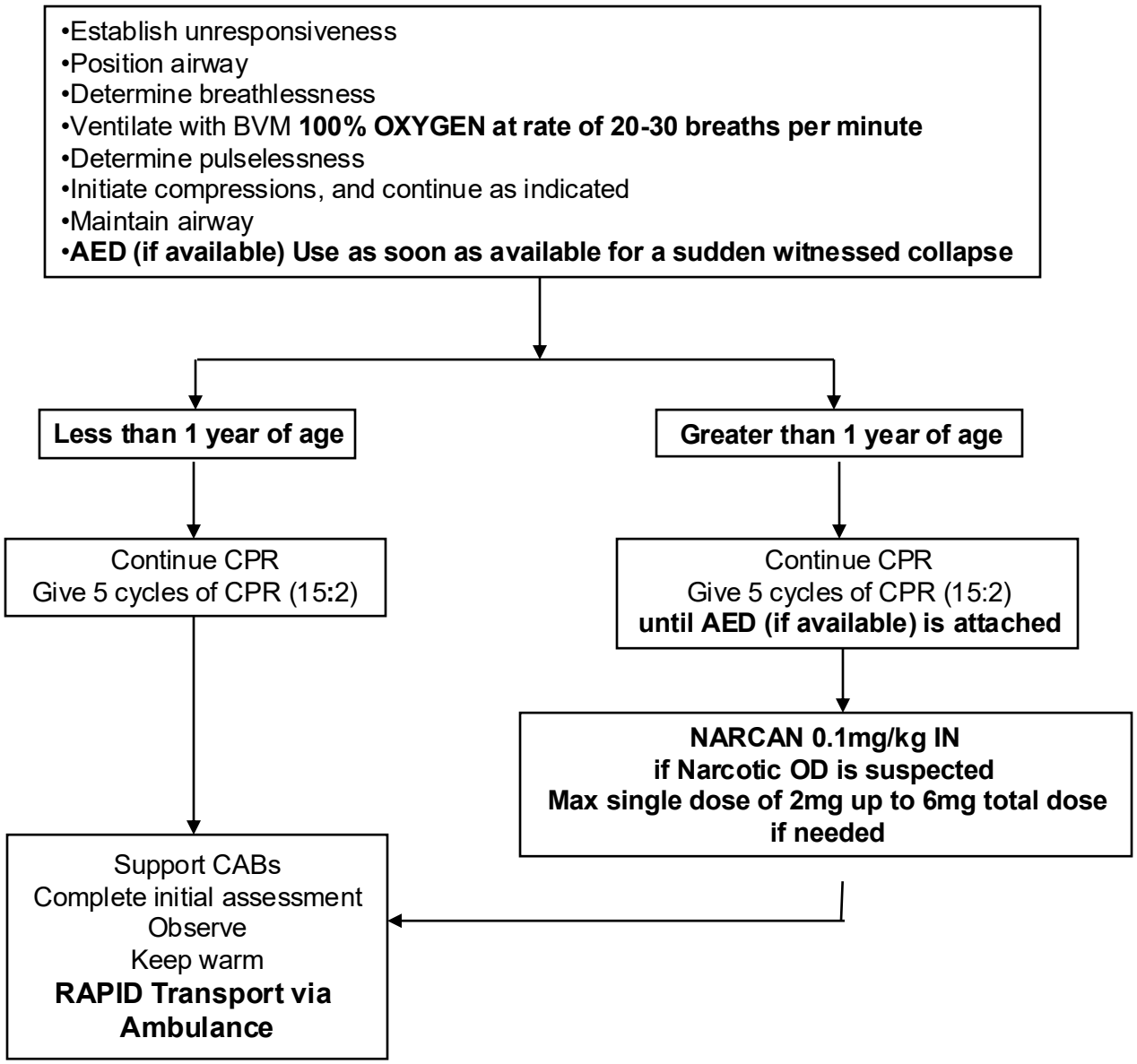
To effectively maintain awareness of changes in patient's condition, repeated assessments are essential and should be performed at least every 5 minutes on the unstable patient, and at least every 15 minutes on the stable patient.

7. CONSIDERATIONS FOR CHILDREN WITH SPECIAL HEALTHCARE NEEDS (CSHN)

- Be familiar with CSHN in your service community and with both the child as well as their anticipated emergency care needs.
- Refer to child's emergency care plan formulated by their medical providers, (if available). Understanding the child's baseline will assist in determining the significance of altered physical findings. Parents/caregivers are the best source of information on: medications, baseline vitals, functional level/normal mentation, likely medical complications, equipment operation and troubleshooting, emergency procedures.
- Regardless of underlying condition, assess in a systematic and thorough manner. Use parents/caregivers/home health nurses as medical resources.
- Be prepared for differences in airway anatomy, physical development, cognitive development and possibly existing surgical alterations or mechanical adjuncts. Common home therapies include: respiratory support (oxygen, apnea monitors, pulse oximeters, tracheostomies, mechanical ventilators), nutrition therapy (nasogastric or gastrostomy feeding tubes), intravenous therapy (central venous catheters), urinary catheterization or dialysis (continuous ambulatory peritoneal dialysis), biotelemetry, ostomy care, orthotic devices, communication or mobility devices, or hospice care.
- Communicate with the child in an age appropriate manner. Maintain communication with and remain sensitive to the parents/caregivers and the child.
- The most common emergency encountered with these patients is respiratory related and so familiarity with respiratory emergency interventions/adjuncts/treatment is appropriate.

Protocol 58

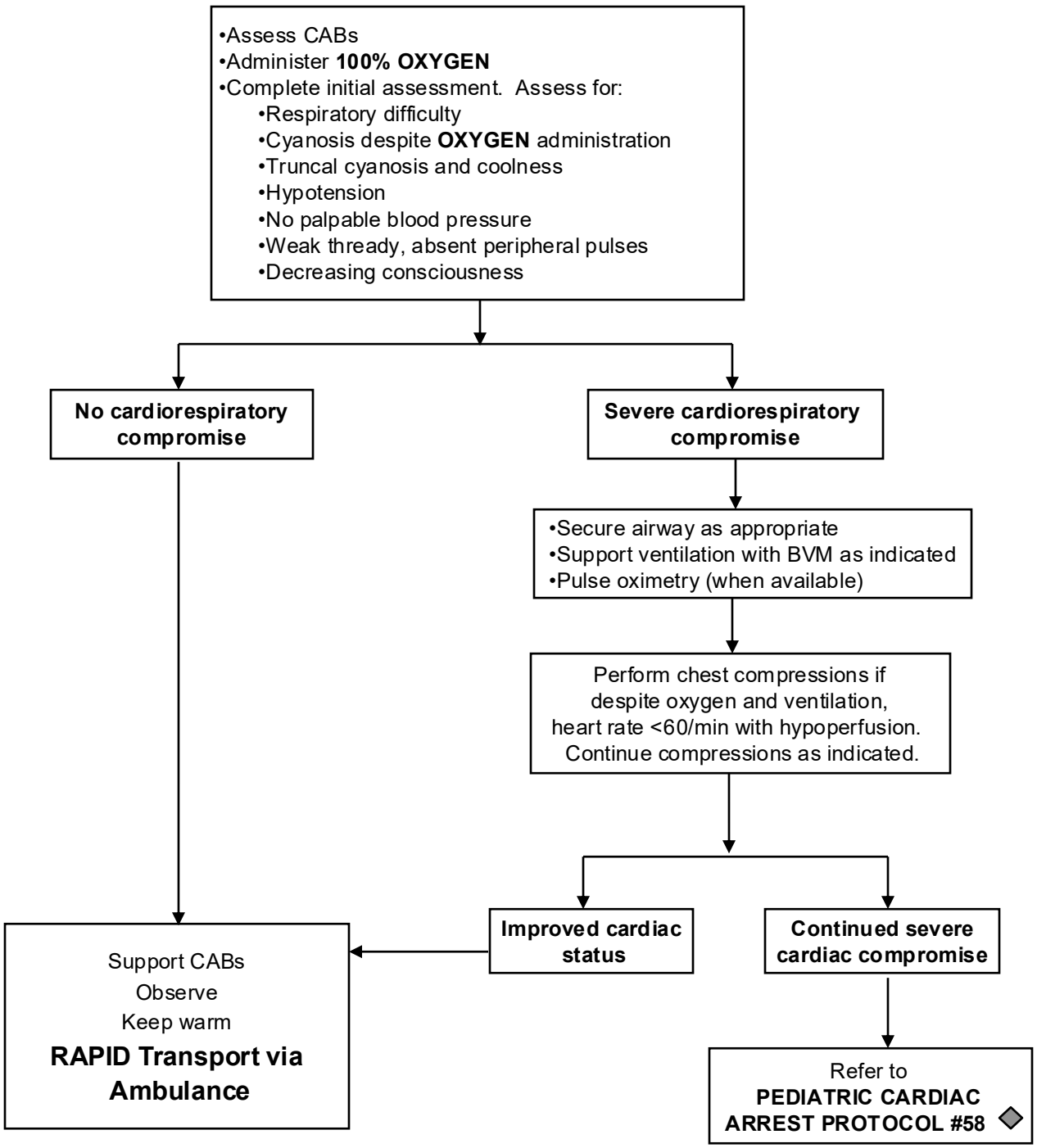
PEDIATRIC CARDIAC ARREST



NOTE TO PREHOSPITAL PROVIDERS:
In patients ages 1-8 use pediatric defibrillation pads (if available)

Protocol 59

PEDIATRIC BRADYCARDIA

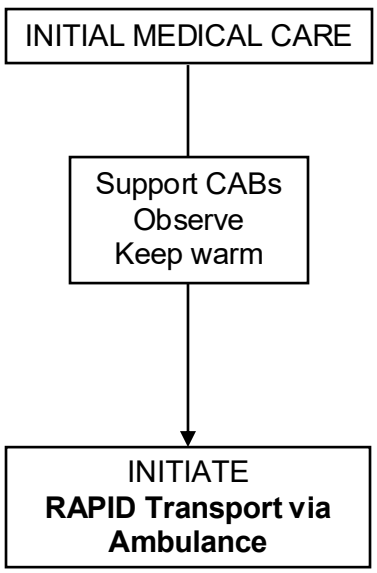


NOTE TO PREHOSPITAL PROVIDERS:

1. Hypoglycemia has been known to cause bradycardia in infants.
2. Refer to **PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS PROTOCOL #66**
3. Special conditions may apply in the presence of severe hypothermia.
4. Refer to **PEDIATRIC COLD EMERGENCIES PROTOCOL #69** as needed.

Protocol 60

PEDIATRIC TACHYCARDIA



NOTE TO PREHOSPITAL PROVIDERS:

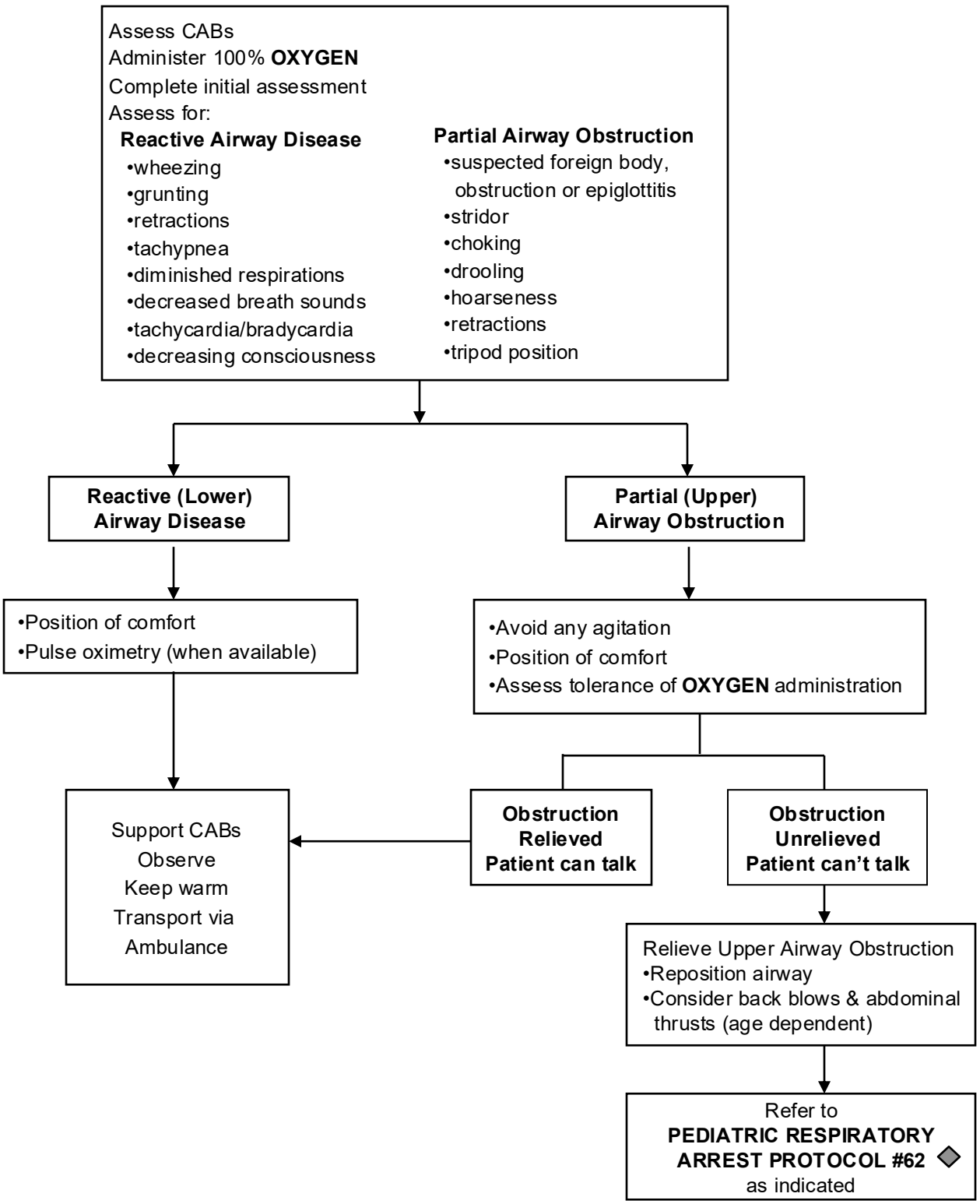
Vagal maneuvers may precipitate asystole and therefore should be employed with caution and only when authorized by **Medical Control**

Refer to **PEDIATRIC SHOCK PROTOCOL #63** ◇ **if patient has signs of severe cardiorespiratory compromise:**

- Respiratory distress
- Truncal cyanosis and coolness
- Weak thready, or absent peripheral pulses
- Hypotension/no palpable blood pressure
- Decreasing consciousness

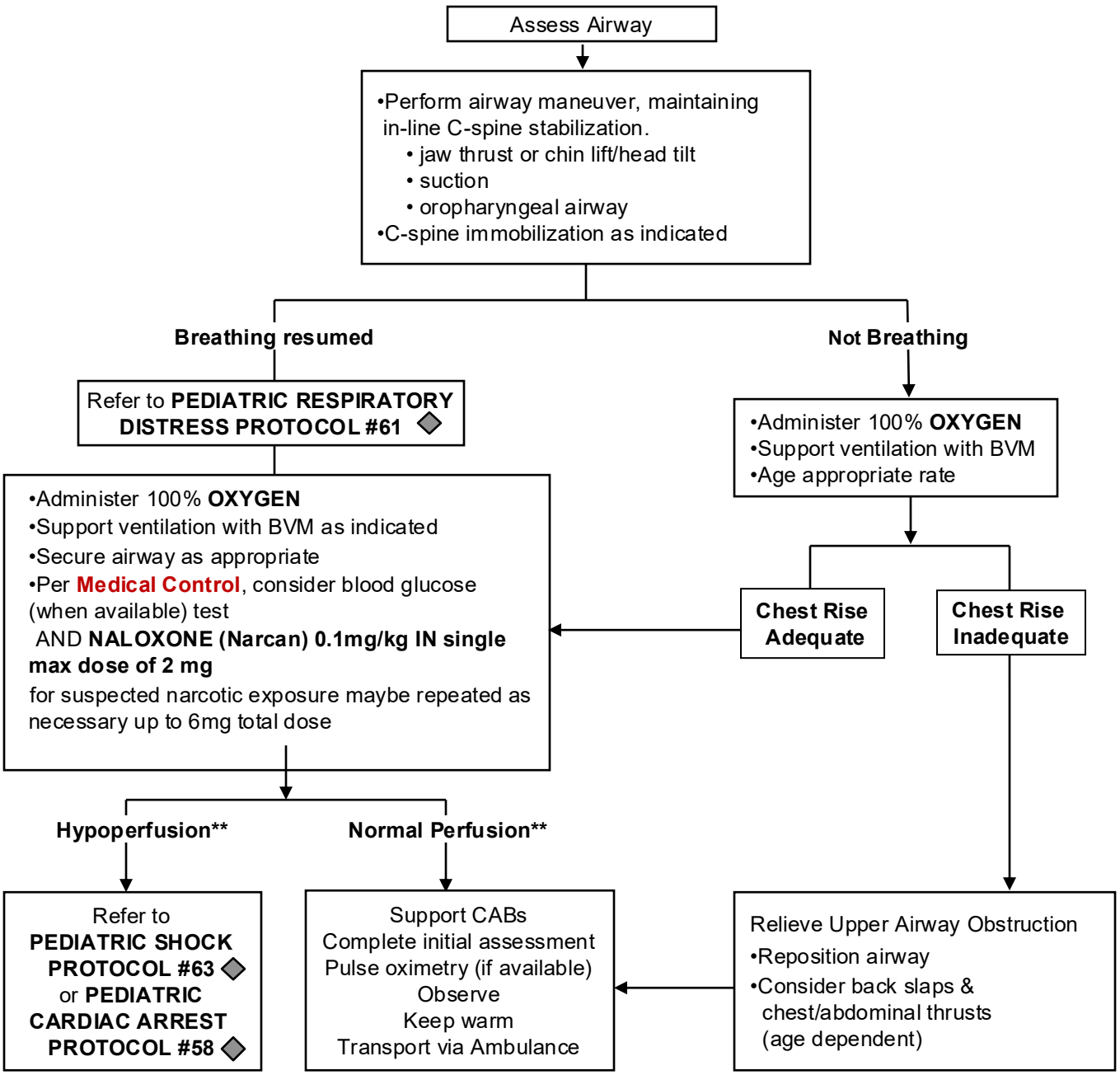
Protocol 61

PEDIATRIC RESPIRATORY DISTRESS



Protocol 62

PEDIATRIC RESPIRATORY ARREST



NOTE TO PREHOSPITAL PROVIDERS:

Respiratory arrest may be a presenting sign of a toxic ingestion or metabolic disorder.

Refer to **PEDIATRIC ASSESSMENT AND TRAUMA SCORE PROTOCOL #34

Protocol 63

PEDIATRIC SHOCK

Pediatric Shock Vital Signs:

0 – 5 mos of age:	Sys BP < 60 mmHg
6 mos – 5 yrs:	Sys BP < 70 mmHg, HR < 70
≥ 6yrs:	Sys BP < 80 mmHg, HR < 60

INITIAL MEDICAL CARE

↓

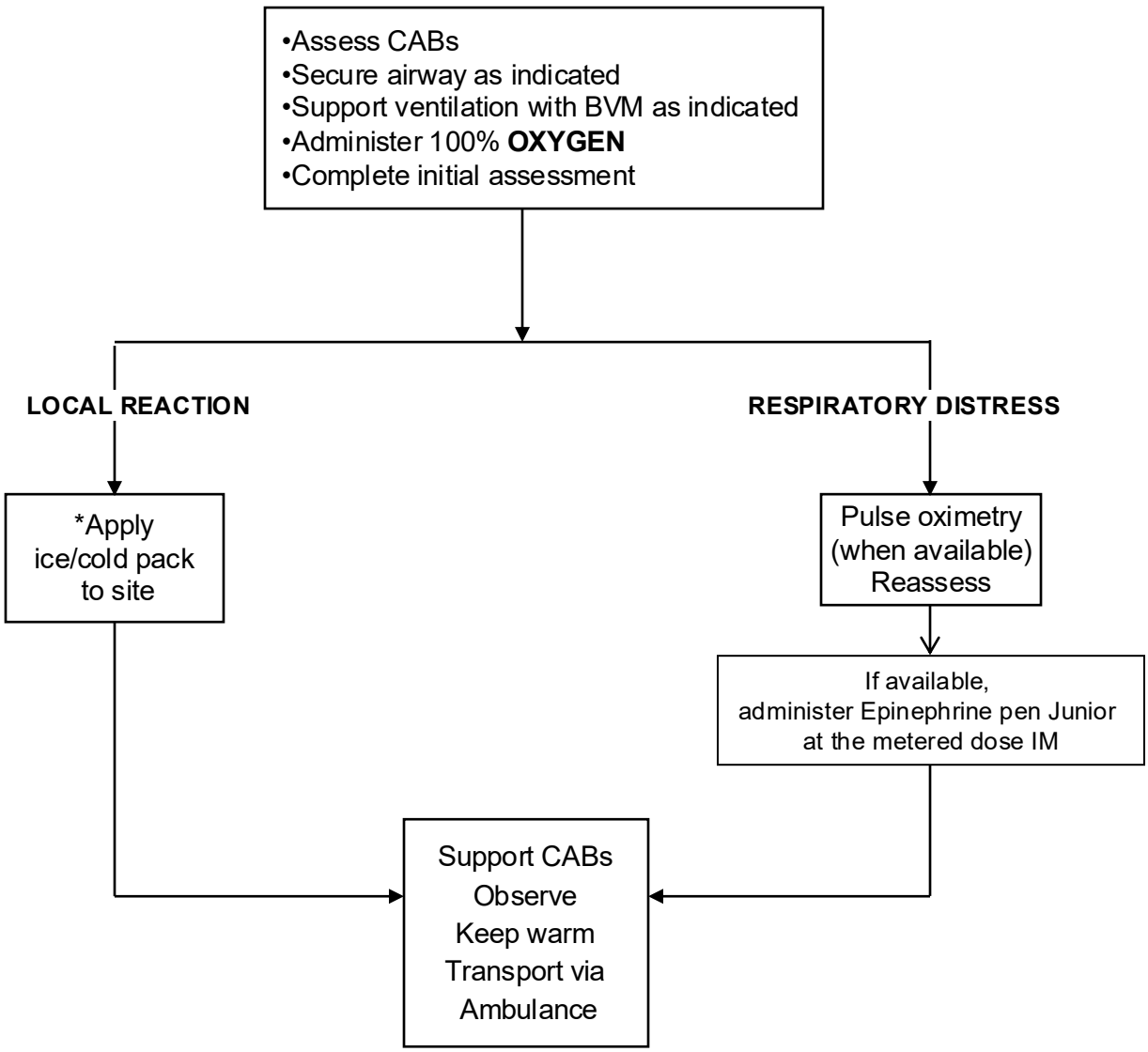
100% **OXYGEN**
Assist ventilation with BVM if indicated
Complete initial assessment
Transport in Supine position

↓

Support CABs
Pulse oximetry (when available)
Observe
Keep warm
Transport via Ambulance

Protocol 64

PEDIATRIC ALLERGIC REACTION ANAPHYLAXIS

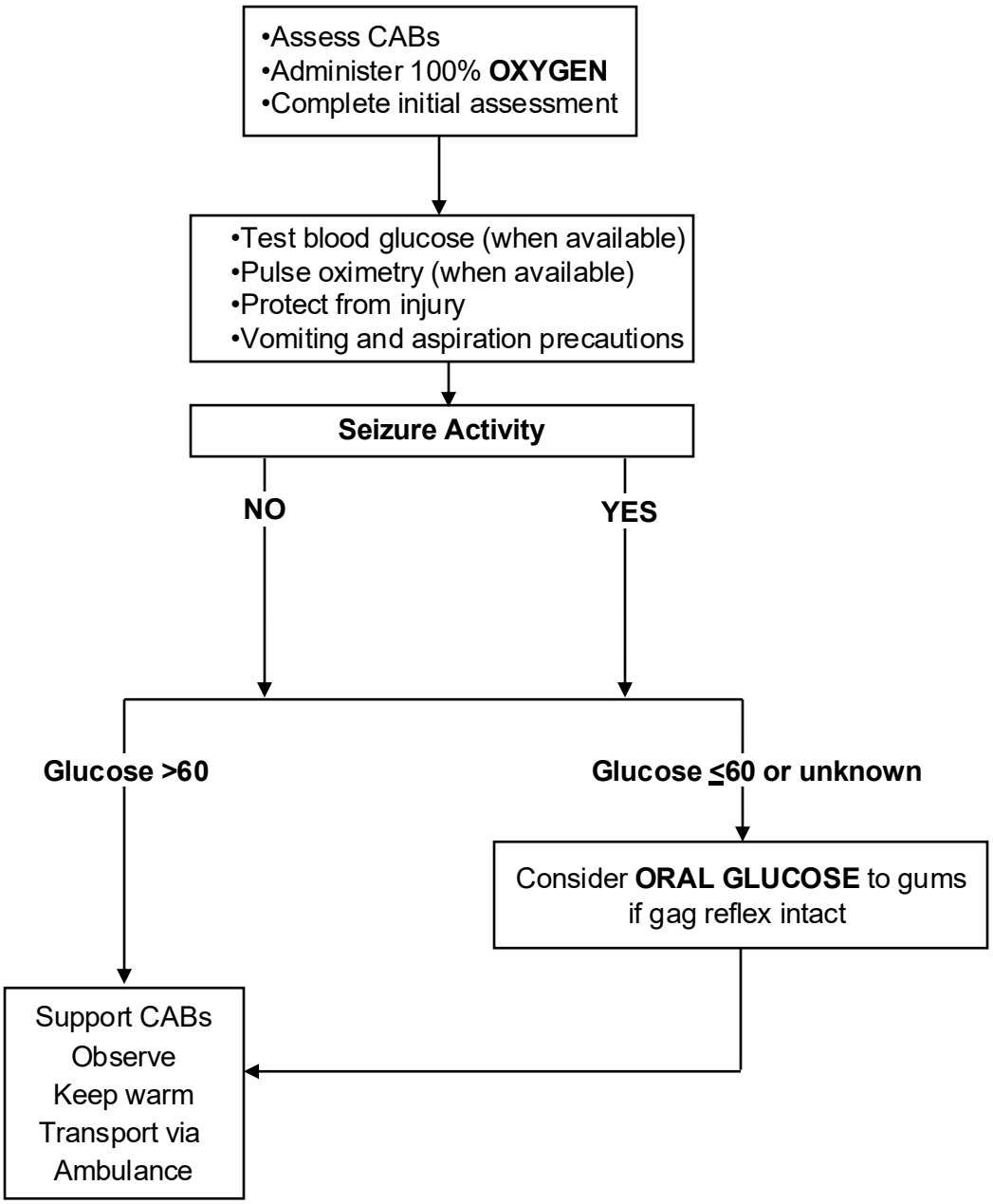


NOTE TO PREHOSPITAL PROVIDERS:

*Simple hives do not require any additional field treatment.

Protocol 65

PEDIATRIC SEIZURES



NOTE TO PREHOSPITAL PROVIDERS:

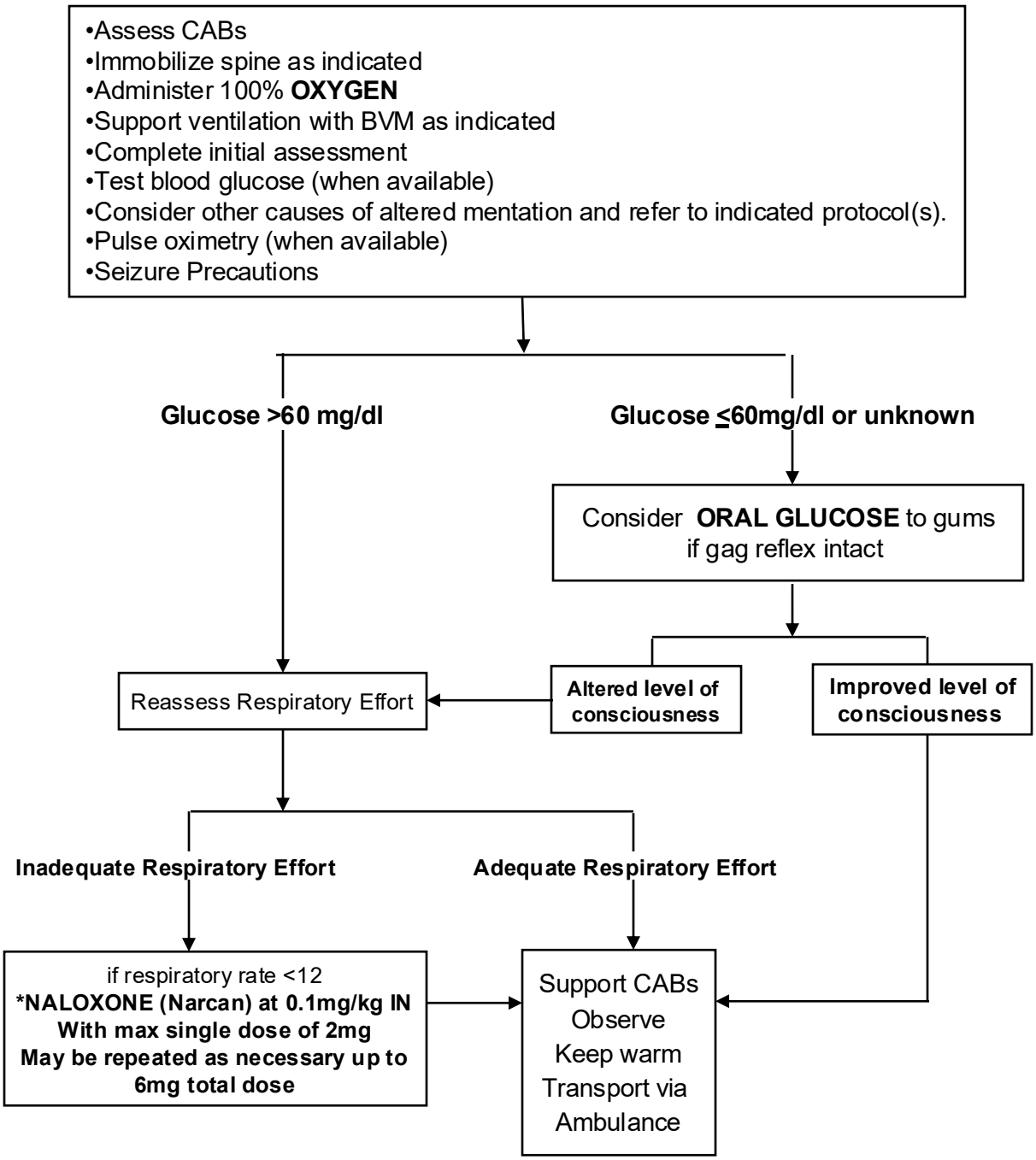
Refer to **PEDIATRIC RESPIRATORY ARREST PROTOCOL #62** as indicated

For suspected ACUTE narcotic exposure consider NALOXONE (Narcan) 0.1mg/kg IN with max single dose of 2mg

May be repeated as necessary up to 6 mg total dose

Protocol 66

PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS/BRUE *BRIEF RESOLVED UNEXPLAINED EVENT



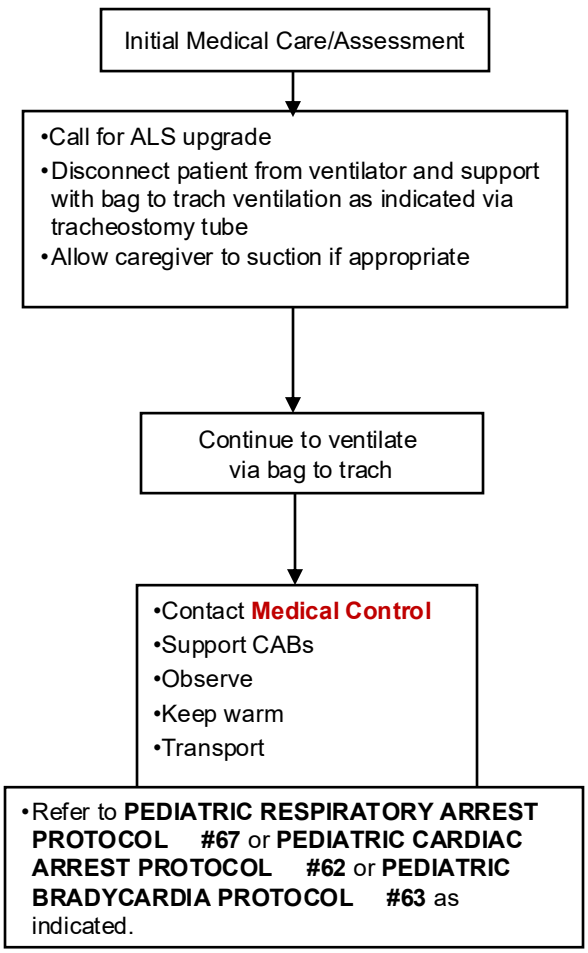
NOTE TO PREHOSPITAL PROVIDERS:

***NALOXONE (Narcan)** should be used only for suspected ACUTE narcotic exposure.

PEDIATRIC

Protocol 66a

PEDIATRIC RESPIRATORY DISTRESS WITH A VENTILATOR



Special Considerations:

- **NOTE: Ventilate via bag to trach until you achieve chest rise. Find out from parent the child's baseline ventilatory rate, and match with bag rate.**
- **Use parents/caregivers/home health nurses as medical resources at home and enroute.**
- Alert Medical Control of parent/caregiver participation in care.
- Allow caregiver to remain with child regardless of child's level of responsiveness.
- Bring ventilator to the hospital or have parents/caregivers bring the ventilator to the hospital.

PEDIATRIC

Protocol 66b

PEDIATRIC RESPIRATORY DISTRESS WITH A TRACHEOSTOMY TUBE

Initial Medical Care/Assessment

- Call for ALS upgrade
- Administer 15L **OXYGEN** via tracheostomy/stoma or non-rebreather mask
- Monitor Pulse Oximetry per patient baseline, if available
- Allow caregiver to suction if appropriate

Continued respiratory distress

- Support with bag to trach ventilation as indicated via tracheostomy tube

- Contact **Medical Control**
- Support CABs
- Observe
- Keep warm
- Transport

- Refer to **PEDIATRIC RESPIRATORY ARREST PROTOCOL #67** or **PEDIATRIC CARDIAC ARREST PROTOCOL #62** or **PEDIATRIC BRADYCARDIA PROTOCOL #63** as indicated.

Special Considerations:

- Use parents/caregivers/home health nurses as medical resources at home and enroute
- Alert **Medical Control** of parent/caregiver participation in care.
- Allow caregiver to remain with child regardless of child's level of responsiveness.

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Protocol 67

PEDIATRIC TOXIC EXPOSURES / INGESTIONS

Assess scene safety as indicated:
- Appropriate body substance isolation
- Refer to appropriate **HAZMAT PROTOCOL #45-49** ◇
- Stop exposure

Assess CABs
Secure airway as appropriate
Support ventilation with BVM as indicated
Administer 100% **OXYGEN**
Pulse oximetry (when available)
Complete initial assessment

↓

Initial interventions per **Medical Control** as indicated for identified exposure
Support CABs
Observe
Bring container(s) of drug or substance to the ED
Transport via Ambulance

↓

EXPOSURE TO OR INGESTION OF NARCOTICS OR UNKNOWN SUBSTANCES

For altered level of consciousness consider:
- **NALOXONE (Narcan) at 0.1mg/kg IN** if respiratory rate <12. Max single dose 2mg
- May be repeated as necessary up to 6mg total dose
- If seizures occur, refer to **PEDIATRIC SEIZURES PROTOCOL #65** ◇ as indicated
- **DO NOT INDUCE VOMITING.**

POTENTIAL EXPOSURES

- Burning overstuffed furniture = Cyanide
- Old burning buildings = Lead fumes and Carbon monoxide
- Pepto-Bismol = Aspirin
- Pesticides = Organophosphates & Carbamates
- Common poisonous plants: Dieffenbachia, Foxglove, Holly leaves and berries, Lilly of the Valley, Nightshade, Philodendron, Rhubarb leaves, and Tobacco
- Smells:
  - Almond = Cyanide
  - Fruit = Alcohol
  - Garlic = Arsenic, parathion, DMSO
  - Mothballs = Camphor
  - Natural gas = Carbon monoxide
  - Rotten eggs = Hydrogen sulfide
  - Silver polish = Cyanide
  - Stove gas = Think CO (CO and methane are odorless)
  - Wintergreen = Methyl salicylate

NOTE TO PREHOSPITAL PROVIDERS:

1. Anticipate vomiting, respiratory arrest, seizure, dysrhythmias and refer to indicated protocol(s). ◇
2. Do not induce vomiting.

Protocol 68

PEDIATRIC HEAT EMERGENCIES

- Assess CABs
- Administer 100% **OXYGEN**
- Complete initial assessment. Assess for:
  - Hot, dry, flushed or ashen skin
  - Tachycardia
  - Tachypnea
  - Diaphoresis
  - Decreasing consciousness
  - Profound weakness and fatigue
  - Vomiting, diarrhea
  - Hypoperfusion
  - Muscle cramps
- Assess scene for environmental risks
  - Place in a cool environment
  - Remove clothing as appropriate

Normal Level of Consciousness & Diaphoresis

Decreased Consciousness, Dry Skin

Systolic BP ≥ 100

Hypoperfusion* or Presence of Nausea/Vomiting

Adequate Respiratory Effort

Inadequate Respiratory Effort

**Initiate cooling

Refer to **PEDIATRICSEIZURES PROTOCOL #65** ◇ as indicated

Secure airway as appropriate

Support ventilation with BVM

Give cool liquids PO

Support CABs
Observe
Transport via Ambulance

NOTE TO PREHOSPITAL PROVIDERS:

****Cooling Techniques**

1. Apply cool pack to head, neck, armpits, groin, behind knees and to lateral chest.
2. Tepid water per sponge/spray
3. Manually fan body to evaporate and cool
4. **Stop cooling if shivering occurs.**

*Refer to **PEDIATRIC ASSESSMENT AND TRAUMA SCORE PROTOCOL #34** ◇

Protocol 69

PEDIATRIC COLD EMERGENCIES

Frostbite

Move patient to a warm environment as soon as possible

- Handle skin like a burn
- Protect with light sterile dressings.
- Do not let skin rub on skin (between fingers or toes).
- Do not forcibly remove clothing that sticks to the affected area.

Cover patient and prevent re-exposure.

Transport via Ambulance

Systemic Hypothermia

Mild/Moderate
86-93.2 F(30-34 C):
Conscious
OR
altered sensorium with shivering

OXYGEN 12-15 L/mask

Rewarm patient:
- Place patient in a warm environment.
- Remove wet clothing.
- Apply hot packs wrapped in towels to axilla, groin, neck, thorax.
- Wrap patient in blankets.

Transport via Ambulance

Severe Hypothermia

86 F or less (<30 C):
- HANDLE PATIENT VERY GENTLY TO AVOID PRECIPITATING V-FIB.
- Patient may appear uncoordinated with poor muscle control, or stiff simulating rigor mortis.
- There will be NO SHIVERING.
- Level of consciousness may be confused, lethargic and/or withdrawn
- Coma

TRIPLE ZERO CANNOT BE CONFIRMED FROM THE FIELD ON THESE PATIENTS *

OXYGEN 100%
Do not hyperventilate

Transport via Ambulance

*** NOTE TO PREHOSPITAL PROVIDERS:**

Assess pulse for 30-45 seconds before beginning CPR.

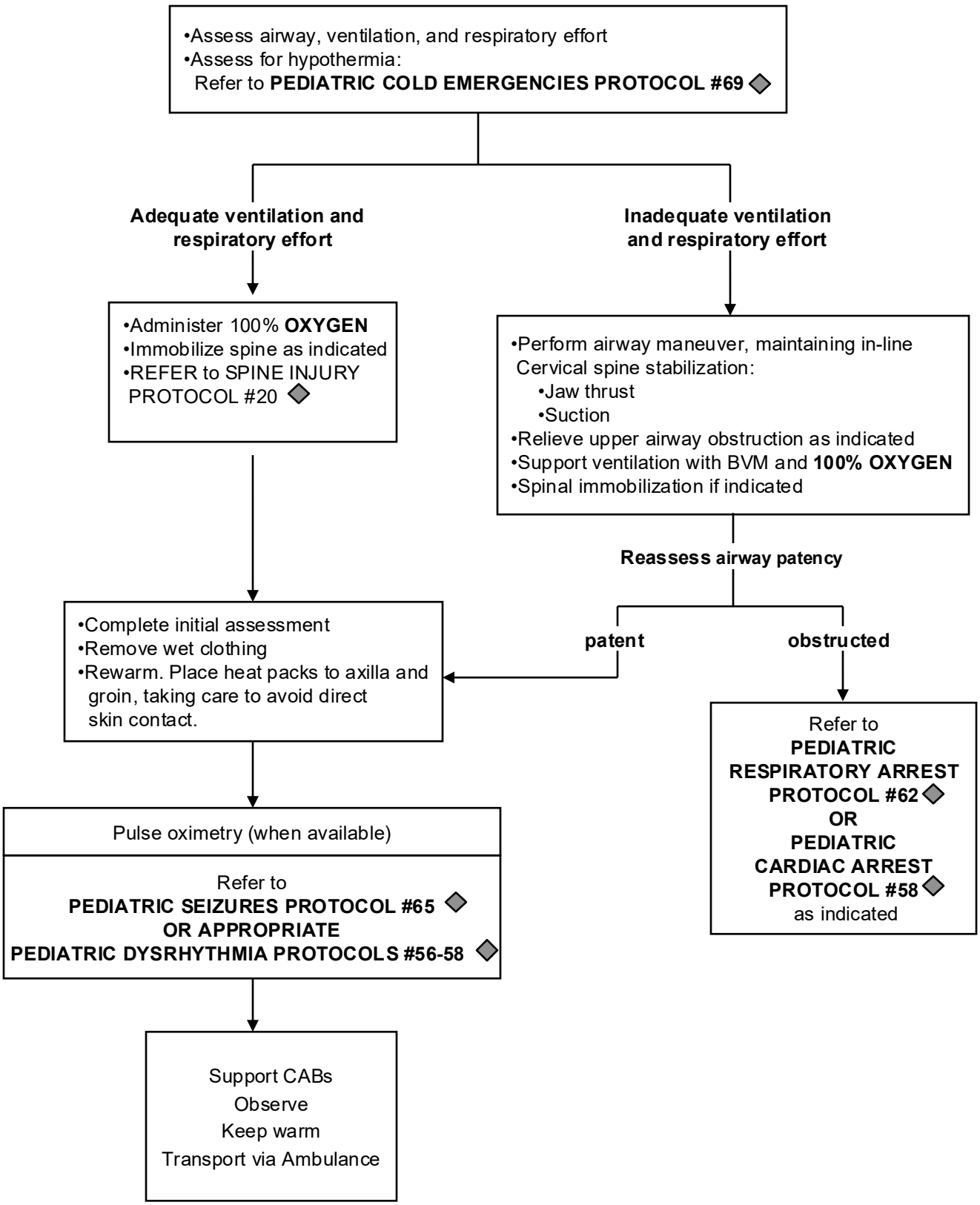
Begin CPR only if pulseless and not breathing.

Apply AED (if available). May attempt defibrillation x 1.

Refer to **PEDIATRIC CARDIAC ARREST PROTOCOL #58** ◇

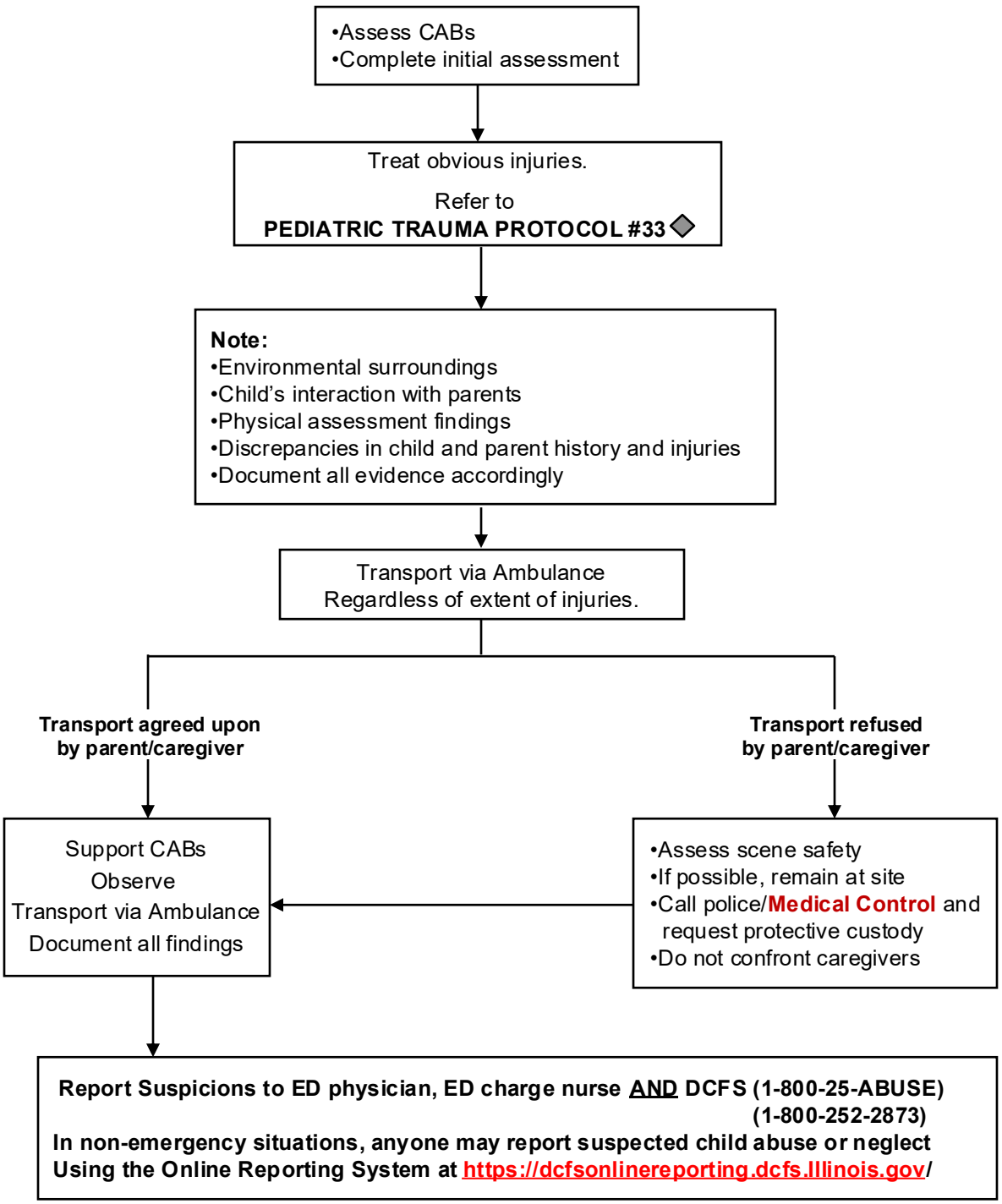
Protocol 70

PEDIATRIC DROWNING



Protocol 71

SUSPECTED CHILD ABUSE AND NEGLECT
PAGE 1 OF 2



Protocol 71

SUSPECTED CHILD ABUSE AND NEGLECT
PAGE 2 OF 2

NOTE TO PREHOSPITAL PERSONNEL:

1. You are required by law to report your suspicions.

2. Suspect battered or abused child if any of the following is found:
   - A discrepancy exists between history of injury and physical exam.
   - Caregiver provides a changing or inconsistent history.
   - There is a prolonged interval between injury and the seeking of medical help.
   - Child has a history of repeated trauma.
   - Caregiver responds inappropriately or does not comply with medical advice.
   - Suspicious injuries are present, such as:
     - Injuries of soft tissue areas, including the face, neck and abdomen
     - Injuries of body areas that are normally shielded, including the back and chest
     - Fractures of long bones in children under 3 years of age
     - Old scars, or injuries in different stages of healing
     - Bizarre injuries, such as bites, cigarette burns, rope marks, imprint of belt or other object
     - Trauma of genital or perianal areas
     - Sharply demarcated burns in unusual areas
     - Scalds that suggest child was dipped into hot water

3. The following are some common forms of neglect:

   - Environment is dangerous to the child (e.g. weapons within reach, playing near open windows without screen/guards, perilously unsanitary conditions, etc.).

   - Caretaker has not provided, or refuses to permit medical treatment of child's acute or chronic life-threatening illness, or of chronic illness, or fails to seek necessary and timely medical care for child.

   - Abandonment

   - Caretaker appears to be incapacitated (e.g. extreme drug/alcohol intoxication, disabling psychiatric symptoms, prostrating illness) and cannot meet child's care requirements.

   - Child appears inadequately fed (e.g. seriously underweight, emaciated, or dehydrated) inadequately clothed, or inadequately sheltered.

   - Child is found to be intoxicated or under the influence of an illicit substance(s).

Protocol 72

DOMESTIC VIOLENCE, SPOUSAL ABUSE, GERIATRIC ABUSE, AND SEXUAL ASSAULT

1. PURPOSE/DEFINITION

Given the magnitude of the problems of abuse and violence in our society, early detection of domestic violence victims, appropriate legal and social service referrals and the delivery of timely medical care are essential. Domestic violence is a pattern of coercive behavior engaged in by someone who is or who was in an intimate or family relationship with the recipient. These behaviors may include: repeated battering, psychological abuse, sexual assault or social isolation such as restricted access to money, friends, transportation, health care or employment. Typically, the victims are female, but it must be recognized that males can be victims of abuses as well.

2. DOMESTIC VIOLENCE INDICATORS

While sometimes the specific history of abuse is offered, many times the victim of abuse, (either out of fear or because of the coercive nature of the relationship or out of desire to protect the abuser) will not volunteer a true history but instead ascribe injuries to another cause. Therefore, an appropriate review must be undertaken with respect to patients presenting with injuries:

- That do not seem to correspond with the explanation offered.
- That are of varying ages.
- That have the contour of objects commonly used to inflict injury (hand, belt, rope, chain, teeth, cigarette).
- During pregnancy.

Other factors include:

- Partner accompanies patient and answers all questions directed to patient.
- Patient reluctant to speak in front of partner.
- Denial or minimalization of injury by partner or patient.
- Intensive, irrational jealousy or possessiveness expressed by partner.

Physical injuries commonly associated with domestic violence:

- Central injuries, specifically to the face, head, neck, chest, breasts, abdomen, or genital areas.
- Contusions, lacerations, abrasions, stab wounds, burns, human bites, fractures (particularly of the nose and orbits) and spiral wrist fractures
- Complaints of acute or chronic pain without tissue injury
- Signs of sexual assault
- Injuries of vaginal bleeding during pregnancy, spontaneous or threatened miscarriage
- Direct impact of domestic violence on pregnancy may include:
  - Abdominal trauma leading to abruption, pre-term labor, and delivery
  - Fetal fracture
  - Ruptured maternal liver, spleen, uterus
  - Antepartum hemorrhage
  - Exacerbation of chronic illness
- Multiple injuries in different stages of healing

Protocol 72

DOMESTIC VIOLENCE, SPOUSAL ABUSE, GERIATRIC ABUSE, AND SEXUAL ASSAULT PAGE 2 OF 2

3. APPROACHES FOR INTERVIEWING THE PATIENT

The goals of the physical examination are to identify injuries requiring further medical intervention and to make observations and collect evidence that may corroborate the patient's report of abuse. A thorough physical examination is essential to uncover hidden injuries or compensated trauma. If the patient reports sexual assault, the **DOMESTIC VIOLENCE/SPOUSAL ABUSE/GERIATRIC ABUSE/SEXUAL ASSAULT PROTOCOL #72** ◆ should be followed:

- Always interview the patient in a private place, away from anyone accompanying them to the ED. Questioning the patient in front of the batterer may place the patient and any children in danger.
- You may be the first person or professional to acknowledge the abuse. It is important that you convey your concerns about what has happened to the patient to the Emergency Physician and Nurse.
- When interviewing, do not ask the patients if they were battered or abused (many battered persons do not consider themselves in this light). Instead you can ask the patient:
  - "Have you had a fight with someone?"
  - "Did anyone hurt you?"
  - "Many times we have seen these types of injuries in patients who are hurt by someone else, did someone hurt you?"
  - "I am concerned that someone may be hurting you or scaring you, can you tell me what happened?"
- Most battered persons feel very shamed and humiliated about what has happened to them. It is important to acknowledge that you understand how difficult it is to talk about what has happened.
- Many battered persons will minimize the abuse or blame themselves for what happened. It is important that you repeatedly reinforce that no one deserves to be hurt no matter what they may or may not have done.
- Questions/attitude **Not** to Ask/Express:
  - What keeps you with a person like that?
  - Do you get something out of the violence?
  - What did you do at the moment that caused them to hit you?
  - What could you have done to avoid or defuse the situation?

4. PRACTICE

- Treat obvious injuries; transport.
- Report your suspicion and supporting findings to the Emergency Department Physician and on the prehospital report form.
- Document the name of the physician and/or nurse to whom you reported your suspicion on the prehospital report form.
- If the patient refuses transport, make appropriate referral and document on run sheet.
- Document your findings on the prehospital report form:
  - Presenting condition
  - Any suspicious indicators
  - Any suspicious commentary made by the patient on interviewing the patient.
  - Physical exam including any evidence of abuse.
  - Treatment rendered

Report Suspicions of Geriatric (Elder) Abuse or Neglect to ED physician, ED charge nurse AND the 24-hour Adult Protective Services Hotline 1-866-800-1409

Protocol 73

ADULT RESTRAINTS AND BEHAVIORAL EMERGENCIES

Maintain situational awareness and scene safety. Introduce yourself to the patient, and attempt to gain their confidence in a non-threatening manner. If the patient refuses Assistance, attempt to determine their mental status. This includes determining their orientation and the presence of anything that could produce an altered mental status, such as drug/alcohol intoxication or withdrawal, trauma (head injury), hypoxia, hypotension, hypoglycemia, stroke, infections, psychological emergencies (i.e. homicidal, suicidal, psychosis, etc.) or dementia (i.e. acute or chronic organic brain syndromes).

NO

If the mental status is judged to be abnormal, prehospital personnel must carry out treatment and transport in the patient's best interest.

In any form of intervention, prehospital personnel must ALWAYS CONSIDER THEIR OWN SAFETY FIRST!

1. Again attempt to verbally reassure the patient and seek their willing cooperation.
2. If it is necessary to physically restrain a patient, perform all the following:
   - A. Prepare all the necessary equipment.
   - B. Use police and/or fire personnel if needed. Have one person assigned to each extremity and one to equipment (if available).
   - C. Apply the restraints as loosely as possible to maintain a safe situation, but prevent neurovascular compromise and undue patient discomfort. Apply restraints over clothing when possible.
   - D. Never place restraints over a patient's chest or on the abdomen of a pregnant patient.
   - E. Perform routine and specific medical care as indicated by the patient's condition. Routinely document the neurovascular status of the patient's extremities distal to the restraints.
   - F. Notify the receiving hospital of the situation, and request security assistance upon arrival.
   - G. Continue to attempt to verbally reassure the patient and seek their cooperation. Inform the patient's family of the reasons for the use of restraints.
   - H. Thoroughly document the situation including the reasons for using restraints and how they were applied.
   - I. At no time will towels, washcloths or other devices be placed over the mouth and/or nose of a restrained patient for any reason.
   - J. Never restrain a patient in the prone position.
   - K. For reasons of medical safety, any patient who is under police hold and requires handcuffs, must have a police officer accompany the patient in the back of the ambulance while enroute to the hospital or provide the transporting EMS personnel with keys to the handcuffs.

NOTE TO PREHOSPITAL PROVIDERS:

Once restrained, continue to be conscious of the patient's airway and other medical needs.

Protocol 74

INTRANASAL ADMINISTRATION

- Observe body substance isolation at all times
- Assess ABC's and support ventilation as needed
- Inspect medication
  - Identify concentration
  - Inspect for contamination
  - Check expiration date

- For suspected Opiate overdose

- Remove the medication atomization device (MAD) tip from the syringe
- Draw up **NALOXONE** (Narcan) 0.1mg/kg with a max single dose of 2 mg and replace the MAD Intranasal Atomizer tip
- (OR place the MAD tip on a luer-lock prefilled syringe)
- Pediatric dose of Narcan is <u>half the total dose given in each nare</u>
- NALOXONE (Narcan) may be repeated as necessary up to 6mg total dose
- Tilt the patients head back, if possible
- Place atomizer in the nare opening and advance it until the cone tip is sealed against the opening
- Depress the plunger and administer briskly in each nostril
- Remove the device
- Monitor the patient for desirable and undesirable effects
- Continue to support respirations as needed

Protocol 75

DEFIBRILLATION

- Place the patient in a safe environment, away from pooled water and metal surfaces.
- In patients 1-8 years of age, use pediatric defibrillation pads, if available.
- Apply AED electrode pads to patient chest or appropriate conductive medium to chest
- Follow prompts for defibrillation by AED

MEDICAL

Protocol 76

DIVING (SCUBA INJURY)

For assistance, contact the DIVERS ALERT NETWORK (DAN)
(919)684-9111

- Provide OXYGEN 15L NRB
- Remove scuba gear and deflate vest
- If suspected air embolism, place patient in the left lateral recumbent position
- Perform neurologic assessment
- Treat drowning/near drowning per **ADULT DROWNING PROTOCOL ◇ #54**
- Treat hypothermia per **ADULT COLD EMERGENCIES PROTOCOL ◇ #46**
- Treat head injury per **HEAD TRAUMA/UNCONSCIOUS PATIENT PROTOCOL ◇ #24**

↓

- Injury caused by multiple modalities: Trauma, Barotrauma (arterial gas embolism, pneumothorax, dysrhythmias)
- Identify:
  - MOA (Minute of Angle)
  - depth of dive
  - time under water
  - gas mixture used
  - decompression stops
  - water temperature
- Look for associated injuries, signs of hypothermia, respiratory distress, altered sensation, vomiting, confusion.
- Consider decompression illness if symptoms occur within 48 hours of last dive.

↓

TRANSPORT

Appendix A page 1 of 2

WEIGHT CONVERSION TABLE: POUNDS TO KILOGRAMS

WEIGHT CONVERSION TABLE: 2.2 lbs = 1 kg

lbs	kg	lbs	kg	lbs	kg	lbs	kg	lbs	kg	lbs	kg	lbs	Kg	lbs	kg	lbs	Kg
1	0.5	31	14.1	61	27.7	91	41.4	121	55	151	68.6	181	82.3	211	95.9	241	109.5
2	0.9	32	14.5	62	28.2	92	41.8	122	55.5	152	69.1	182	82.7	212	96.4	242	110
3	1.4	33	15	63	28.6	93	42.3	123	55.9	153	69.5	183	83.2	213	96.8	243	110.5
4	1.8	34	15.5	64	29.1	94	42.7	124	56.4	154	70	184	83.6	214	97.3	244	110.9
5	2.3	35	15.9	65	29.5	95	43.2	125	56.8	155	70.5	185	84.1	215	97.7	245	111.4
6	2.7	36	16.4	66	30	96	43.6	126	57.3	156	70.9	186	84.5	216	98.2	246	111.8
7	3.2	37	16.8	67	30.5	97	44.1	127	57.7	157	71.4	187	85	217	98.6	247	112.3
8	3.6	38	17.3	68	30.9	98	44.5	128	58.2	158	71.8	188	85.5	218	99.1	248	112.7
9	4.1	39	17.7	69	31.4	99	45	129	58.6	159	72.3	189	85.9	219	99.5	249	113.2
10	4.5	40	18.2	70	31.8	100	45.5	130	59.1	160	72.7	190	86.4	220	100	250	113.6
11	5	41	18.6	71	32.3	101	45.9	131	59.5	161	73.2	191	86.8	221	100.5	251	114.1
12	5.4	42	19.1	72	32.7	102	46.4	132	60	162	73.6	192	87.3	222	100.9	252	114.5
13	5.9	43	19.5	73	33.2	103	46.8	133	60.5	163	74.1	193	87.7	223	101.4	253	115
14	6.4	44	20	74	33.6	104	47.3	134	60.9	164	74.5	194	88.2	224	101.8	254	115.5
15	6.8	45	20.5	75	34.1	105	47.7	135	61.4	165	75	195	88.6	225	102.3	255	115.9
16	7.3	46	20.9	76	34.5	106	48.2	136	61.8	166	75.5	196	89.1	226	102.7	256	116.4
17	7.7	47	21.5	77	35	107	48.6	137	62.3	167	75.9	197	89.5	227	103.2	257	116.8
18	8.2	48	21.8	78	35.5	108	49.1	138	62.7	168	76.4	198	90	228	103.6	258	117.3
19	8.6	49	22.3	79	35.9	109	49.5	139	63.2	169	76.8	199	90.5	229	104.1	259	117.7
20	9.1	50	22.7	80	36.4	110	50	140	63.6	170	77.3	200	90.9	230	104.5	260	118.2
21	9.5	51	23.2	81	36.8	111	50.5	141	64.1	171	77.7	201	91.4	231	105	261	118.6
22	10	52	23.6	82	37.3	112	50.9	142	64.5	172	78.2	202	91.8	232	105.5	262	119.1
23	10.5	53	24.1	83	37.7	113	51.4	143	65	173	78.6	203	92.3	233	105.9	263	119.5
24	10.9	54	24.5	84	38.2	114	51.8	144	65.5	174	79.1	204	92.7	234	106.4	264	120
25	11.4	55	25	85	38.6	115	52.3	145	65.9	175	79.5	205	93.2	235	106.8	265	120.5
26	11.8	56	25.5	86	39.1	116	52.7	146	66.4	176	80	206	93.6	236	107.3	266	120.9
27	12.3	57	25.9	87	39.5	117	53.2	147	66.8	177	80.5	207	94.1	237	107.7	267	121.4
28	12.7	58	26.4	88	40	118	53.6	148	67.3	178	80.9	208	94.5	238	108.2	268	121.8
29	13.2	59	26.8	89	40.5	119	54.1	149	67.7	179	81.4	209	95	239	108.6	269	122.3
30	13.6	60	27.3	90	40.9	120	54.5	150	68.2	180	81.8	210	95.5	240	109.1	270	122.7

Revised 5/28/2025
EMR

Appendix A page 2 of 2

WEIGHT CONVERSION TABLE: 2.2 lbs = 1 kg

lbs	kg	lbs	kg	lbs	kg	lbs	kg	lbs	kg	lbs	kg	lbs	Kg
271	122.9	301	136.5	331	150.1	361	163.7	391	177.3	421	190.9	451	204.5
272	123.3	302	136.9	332	150.5	362	164.2	392	177.8	422	191.4	452	205
273	123.8	303	137.4	333	151	363	164.6	393	178.2	423	191.8	453	205.4
274	124.2	304	137.8	334	151.4	364	165.1	394	178.8	424	192.3	454	205.9
275	124.7	305	138.3	335	151.9	365	165.5	395	179.1	425	192.7	455	206.3
276	125.1	306	138.7	336	152.4	366	166	396	179.6	426	193.2	456	206.8
277	125.6	307	139.2	337	152.8	367	166.4	397	180	427	193.6	457	207.2
278	126	308	139.7	338	153.3	368	166.9	398	180.5	428	194.1	458	207.7
279	126.5	309	140.1	339	153.7	369	167.3	399	180.9	429	194.5	459	208.1
280	127	310	140.6	340	154.2	370	167.8	400	181.4	430	195.0	460	208.6
281	127.4	311	141	341	154.6	371	168.2	401	181.8	431	195.4	461	209.1
282	127.9	312	141.5	342	155.1	372	168.7	402	182.3	432	195.9	462	209.5
283	128.3	313	141.9	343	155.5	373	169.1	403	182.7	433	196.4	463	210
284	128.8	314	142.4	344	156	374	169.6	404	183.2	434	196.8	464	210.4
285	129.2	315	142.8	345	156.4	375	170	405	183.7	435	197.3	465	210.9
286	129.7	316	143.3	346	156.9	376	170.5	406	184.1	436	197.7	466	211.3
287	130.1	317	143.7	347	157.9	377	171	407	184.6	437	198.2	467	211.8
288	130.6	318	144.2	348	157.8	378	171.4	408	185	438	198.6	468	212.2
289	131	319	144.6	349	158.3	379	171.9	409	185.5	439	199.1	469	212.7
290	131.5	320	145.1	350	158.7	380	172.3	410	185.9	440	199.5	470	213.1
291	131.9	321	145.6	351	159.2	381	172.8	411	186.4	441	200	471	213.6
292	132.4	322	146	352	159.6	382	173.2	412	186.8	442	200.4	472	214
293	132.9	323	146.5	353	160.1	383	173.7	413	187.3	443	200.9	473	214.5
294	133.3	324	146.9	354	160.5	384	174.1	414	187.7	444	201.3	474	215.
295	133.8	325	147.4	355	161	385	174.6	415	188.2	445	201.8	475	215.4
296	134.2	326	147.8	356	161.4	386	175	416	188.6	446	202.3	476	215.9
297	134.7	327	148.3	357	161.9	387	175.5	417	189.1	447	202.7	477	216.3
298	135.1	328	148.7	358	162.3	388	175.9	418	189.6	448	203.2	478	216.8
299	135.6	329	149.2	359	162.8	389	176.4	419	190	449	203.6	479	217.2
300	136	330	149.6	360	163.2	390	176.9	420	190.5	450	204.1	480	217.7

Revised 5/28/2025
EMR