### TAB 5 GUIDELINE 1

**PEDIATRIC TABLES**

<table>
<thead>
<tr>
<th>Age</th>
<th>Pulse (beats/min)</th>
<th>Respirations</th>
<th>Blood Pressure (SBP / DBP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>120 – 160</td>
<td>30 – 60</td>
<td>74 – 100 / 50 – 68</td>
</tr>
<tr>
<td>Infant</td>
<td>100 – 140</td>
<td>30 – 60</td>
<td>84 – 106 / 56 – 70</td>
</tr>
<tr>
<td>Toddler</td>
<td>80 – 130</td>
<td>24 – 40</td>
<td>98 – 106 / 50 – 70</td>
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<tr>
<td>Preschool</td>
<td>80 – 120</td>
<td>22 – 34</td>
<td>98 – 112 / 64 – 70</td>
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<td>School age</td>
<td>60 – 100</td>
<td>18 – 30</td>
<td>104 – 124 / 64 – 80</td>
</tr>
<tr>
<td>Adolescent</td>
<td>50 – 90</td>
<td>12 – 18</td>
<td>118 – 132 / 70 – 82</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Estimated Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10 kg</td>
</tr>
<tr>
<td>3</td>
<td>15 kg</td>
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<tr>
<td>5</td>
<td>20 kg</td>
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<tr>
<td>7</td>
<td>25 kg</td>
</tr>
<tr>
<td>9</td>
<td>30 kg</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE</th>
<th>ORAL AIRWAY</th>
<th>ENDOTRACHEAL TUBE (uncuffed)</th>
<th>SUCTION CATHETER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preemie</td>
<td>00</td>
<td>2.5 - 3.0</td>
<td>5 French</td>
</tr>
<tr>
<td>Newborn</td>
<td>0</td>
<td>3.0 - 3.5</td>
<td>6 French</td>
</tr>
<tr>
<td>6 Months</td>
<td>0 - 1</td>
<td>3.5</td>
<td>8 French</td>
</tr>
<tr>
<td>18 Months</td>
<td>1</td>
<td>4.0</td>
<td>8 French</td>
</tr>
<tr>
<td>3 Years</td>
<td>2</td>
<td>4.5</td>
<td>8 French</td>
</tr>
<tr>
<td>5 Years</td>
<td>2 - 3</td>
<td>5.0</td>
<td>10 French</td>
</tr>
<tr>
<td>8 Years</td>
<td>3</td>
<td>6.0 cuffed</td>
<td>10 French</td>
</tr>
<tr>
<td>Older</td>
<td>4</td>
<td>6.5 - 7.0 cuffed</td>
<td>12 French</td>
</tr>
</tbody>
</table>
# TAB 5 GUIDELINE 2

## ABDOMINAL PAIN

### HISTORY
- Age
- Past medical / surgical history
- Medications
- Onset
- Palliation / Provocation
- Quality (crampy, constant, sharp, dull, etc)
- Region / Radiation / Referred
- Severity (1-10)
- Time (duration / repetition)
- Fever
- Last meal eaten
- Last bowel movement
- Menstrual history (pregnancy)

### SIGNS / SYMPTOMS
- Pain (location / migration)
- Tenderness
- Nausea
- Vomiting
- Diarrhea
- Dysuria
- Constipation
- Vaginal bleeding / discharge
- Pregnancy

### ASSOCIATED SYMPTOMS:
- Fever, headache, weakness, malaise, myalgias, cough, headache, mental status changes, rash

### DIFFERENTIAL
- Pneumonia or Pulmonary embolus
- Liver (hepatitis, CHF)
- Peptic ulcer disease / Gastritis
- Gallbladder / Pancreatitis
- Myocardial infarction
- Kidney stone
- Abdominal aneurysm
- Appendicitis / Diverticulitis
- Bladder / Prostate disorder
- Pelvic (PID, Ectopic pregnancy, Ovarian cyst)
- Spleen enlargement
- Bowel obstruction
- Gastroenteritis (infectious)

---

### Universal Patient Care
- Consider ALS Backup
- Make NPO

### Hypotension / Signs of Dehydration
- Place Supine Position
- Contact ALS Backup
  - Consider ResQGARD (wgt > 25 pounds)

### NO
- Contact Medical Control
- Transport to appropriate facility

---

### Minimum Systolic BP by Age
- < 1 mo: 60 mmHg
- 1 mo to 10 y: 70 + (2 × age in years)
- ≥ 10 y: 90 mmHg

---

### LEGEND
- EMR
- EMT
- A-EMT
- EMT-P
- MC Order
# TAB 5 GUIDELINE 3
## ALLERGIC REACTION | ANAPHYLAXIS

### HISTORY
- Onset and location
- Insect sting or bite
- Food allergy / exposure
- Medication history / allergy / exposure
- New clothing, soap, detergent
- Past history of reactions
- Past medical history

### SIGNS / SYMPTOMS
- Itching or hives
- Coughing / wheezing or respiratory distress
- Chest or throat constriction
- Difficulty swallowing
- Hypotension or shock
- Hypotension or shock / Edema
- Abdominal cramps

### DIFFERENTIAL
- Urticaria (rash only)
- Anaphylaxis (systemic effect)
- Shock (vascular effect)
- Angioedema (drug induced)
- Aspiration / Airway obstruction
- Vasovagal event
- Asthma
- CHF

---

### Universal Patient Care

**Consider ALS Backup**

**Hives / Rash Only**

No Respiratory Component

Reassess Patient

### Respiratory Distress / Shock

**Pulse Oximetry**

**Airway Management**

**EpiPen (Jr) Auto-injector**

- < 30 Kg (66 lbs) and > 15 Kg (33 lbs)

**Albuterol**

1. 25 mg nebulized
   - Wgt < 10 Kg

2. 2.5 mg nebulized
   - (May repeat x 2)

**Contact Medical Control**

Transport to appropriate facility

---

### Indications for Use of Epinephrine

**Respiratory Compromise**
- Airway occlusion
- Breathy difficulty or inadequate breathing with possible wheezing, stridor, or crowing

**Shock**
- Absent or weak pulses
- Rapid heartbeat
- Decreased blood pressure [SBP < 70 + (2 x age) mmHg]
- Deteriorating mental status

### Minimum Systolic BP by Age

- < 1 mo: 60 mmHg
- 1 mo to 10 y: 70 + (2 x age in years)
- ≥ 10 y: 90 mmHg

---

### LEGEND

- EMT
- EMT-P
- A-EMT
- EMR
- MC Order
- EMR
SPECIAL CONSIDERATIONS:

1. Patients with allergic reactions can deteriorate quickly. Airway is a prime concern.

2. Epinephrine (via Auto-Injector) should be administered for:
   a. **Respiratory Compromise**
      i. Airway occlusion
      ii. Breathy difficulty or inadequate breathing with possible wheezing, stridor, or crowing
   
   b. **Shock**
      i. Absent or weak pulses
      ii. Rapid heartbeat
      iii. Decreased blood pressure (SBP < 90 mmHg)
      iv. Deteriorating mental status

3. Lethal edema may be localized to the tongue, uvula or other upper airway structures.

4. If severe reaction with signs | symptoms of shock and / or airway involvement and ALS not available, then administer Epipen Auto-injector for **weight > 30 Kg (66 lbs)**, otherwise use Epipen, Jr for **weight < 30 Kg (66 lbs) and > 15 Kg (33 lbs)**
### TAB 5 GUIDELINE 4
#### ALTERED MENTAL STATUS

**HISTORY**
- < 16 years of age
- Known diabetic, medic alert tag
- Drugs, drug paraphernalia
- Report of illicit drug use or toxic ingestion
- Past medical history
- Mediations
- History of trauma

**SIGNS / SYMPTOMS:**
- Decreased mental status
- Change in baseline mental status
- Bizarre behavior
- Hypoglycemia
  - Cool, diaphoretic skin
  - Fruity breath
  - Kussmaul respirations
  - Signs of dehydration
- Hyperglycemia
  - Warm, dry skin
  - Head trauma
  - CNS (stroke, tumor, seizure, infection)

**DIFFERENTIAL**
- Head trauma
- CNS (stroke, tumor, seizure, infection)
- Cardiac (MI, CHF)
- Pulmonary (hypoxia)
- Infection
- Thyroid (hyper / hypo)
- Shock (septic, metabolic, traumatic)
- Diabetes (hyper / hypoglycemia)
- Toxicologic / Electrolyte abnormality
- Acidosis / Alkalosis
- Environmental exposure
- Psychiatric disorder

---

**Universal Patient Care**

- **Consider Airway Management**
- **Consider ALS Backup**
- **Spinal Immobilization**
  - (if appropriate)
- **Check Blood Glucose**

**Glucose < 60**
- **Oral Glucose**
  - 0.5 Gm / Kg PO
  - (Mental Status?)

**Glucose 60 – 250**
- **Consider other causes:**
  - ALTE
  - Head injury
  - Hypoxia
  - Overdose
  - Stroke

**Glucose > 250**
- **Signs of Dehydration**
- **Consider Use of Restraints**
- **Cardiac Monitor / 12-Lead ECG**
- **Perform procedure if able to transmit, do no delay care to obtain EKG**

**Minimum Systolic BP by Age**
- < 1 mo: 60 mmHg
- 1 mo to 10 y: 70 + (2 × age in years)
- ≥ 10 y: 90 mmHg
**TAB 5 GUIDELINE 5**

**BEHAVIORAL | EXCITED DELIRIUM**

<table>
<thead>
<tr>
<th>HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• &lt; 16 years of age or &gt; 5 years of age</td>
</tr>
<tr>
<td>• Situational crisis</td>
</tr>
<tr>
<td>• Psychiatric illness / medications</td>
</tr>
<tr>
<td>• Injury to self or threats to others</td>
</tr>
<tr>
<td>• Medic alert tag</td>
</tr>
<tr>
<td>• Substance abuse / overdose</td>
</tr>
<tr>
<td>• Diabetes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGNS / SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anxiety, agitation, confusion</td>
</tr>
<tr>
<td>• Affect change, hallucinations</td>
</tr>
<tr>
<td>• Delusional thoughts, bizarre behavior</td>
</tr>
<tr>
<td>• Expression of suicidal / homicidal thoughts</td>
</tr>
<tr>
<td>• Poor concentration, easily distracted, psychosis</td>
</tr>
<tr>
<td>• Combative, violent</td>
</tr>
<tr>
<td>• Large pupils / light sensitivity</td>
</tr>
<tr>
<td>• Tachycardic / Hypertension</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIFFERENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• See Altered Mental Status differential</td>
</tr>
<tr>
<td>• Hypoxia</td>
</tr>
<tr>
<td>• Alcohol intoxication</td>
</tr>
<tr>
<td>• Medication effect / overdose</td>
</tr>
<tr>
<td>• Withdrawal syndromes</td>
</tr>
<tr>
<td>• Depression</td>
</tr>
<tr>
<td>• Bipolar (manic-depressive)</td>
</tr>
<tr>
<td>• Schizophrenia, anxiety disorders, etc.</td>
</tr>
</tbody>
</table>

---

**Universal Patient Care**
- Consider ALS Backup

**Oral Glucose**
- 0.5 Gm / Kg PO (Mental Status?)

**Glucose ≤ 60**
- Check Blood Glucose

**Treat suspected medical or trauma problems per appropriate protocol**
- Altered Mental Status
- Poisoning and Overdose
- Head Trauma

**Remove patient from stressful environment**
- Verbal techniques (reassurance, calm, establish rapport)

**Rapid take-down w/ minimum (4) EMS crew members**
- (If necessary)
- Consider Restraints (for patient / personnel safety)

**Cardiac Monitor / 12-Lead EKG**
- Monitor Respiratory status, consider EtCO₂

**Contact Medical Control**
- Transport to appropriate facility

**LEGEND**
- **EMR**
- **EMT**
- **A-EMT**
- **EMT-P**
- **MC Order**

**Minimum Systolic BP by Age**
- < 1 mo: 60 mmHg
- 1 mo to 10 y: 70 + (2 × age in years)
- ≥ 10 y: 90 mmHg

**Restraints**
- No transport in hobble or prone position.
- Do not inhibit patient breathing, ventilations
SPECIAL CONSIDERATIONS:

1. Excited delirium is an extreme disturbance of consciousness and mental status that occurs in individuals especially when under the influence of stimulants or anti-psychotic medications and it represents an acute **LIFE THREATENING MEDICAL EMERGENCY**
   a. Combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent / bizarre behavior, insensitivity to pain, hyperthermia and increased strength. Potentially life-threatening and associated with use of physical control measures, including physical restraints and Tasers
      i. Need rapid take down, sedation by ALS providers, cooling measures and IV fluid replacement by ALS providers. These patients often suffer respiratory or cardiac arrest once subdued and should be closely monitored and transported by an ALS Unit to closest appropriate facility
   b. Most commonly seen in male subjects with a history of serious mental illness and/or acute or chronic drug abuse, particularly stimulant drugs such as cocaine, crack cocaine, methamphetamine, amphetamines or similar agents
   c. Alcohol withdrawal or head trauma may also contribute to the condition

2. Maintain objectivity during evaluation and treatment. Verbal aggression exhibited by patients can quickly escalate to physical violence. Always proceed with calm, reassuring directions for the patient. If a situation appears threatening, sufficient law enforcement presence may be necessary before patient restraint is attempted
   a. If needing to take the patient down, at minimum, utilize (4) ems crew members / police officers to secure each limb
   b. **If a patient suspected of excited delirium suffers cardiac arrest, consider a fluid bolus and sodium bicarbonate early**

3. Patients requiring physical restraint should be placed in the lateral recumbent position when possible. Consider your own safety and limitations when physical restraint is required.
   a. Restrained patients should never be left unattended. Continue to evaluate effectiveness of restraints and any compromise that may be caused by the restraint process (i.e., airway, breathing, circulation)
   b. Positional asphyxia – very large ventilation volumes are needed to oxygenate and blow off carbon dioxide overload. They should never be left prone or face down in handcuffs and should never by “hog-tied”

4. Do not overlook the possibility of associated domestic violence or abuse
TAB 5 GUIDELINE 6
BRIEF RESOLVED UNEXPLAINED EVENT (BRUE)

1. Specific information needed
   a. An episode in an infant or child less than (2) two years old which is frightening to the
      observer and is characterized by one or more of the following:
      i. Apnea (central or obstructive)
      ii. Skin color change: cyanosis, erythema (redness), pallor, plethora (fluid overload)
      iii. Marked change in muscle tone
      iv. Choking or gagging not associated with feeding or a witnessed foreign body
         aspiration
      v. Seizure-like activity

2. Guideline
   a. Safe scene, universal precautions
   b. ABC (airway, breathing, circulation)
   c. Establish responsiveness (A.V.P.U)
   d. Check Vitals, Pulse Oximeter, Reassure patient
   e. Oxygen by cannula or NRB Mask to keep pulse ox greater than 92% (may have to assist
      ventilation)
   f. Contact on-line MEDICAL CONTROL and transport accordingly

SPECIAL CONSIDERATIONS:
1. Most patients will appear stable and exhibit a normal physical examination. This episode may be
   a sign of an underlying serious illness or injury and further evaluation by medical staff is strongly
   recommended.
2. Provider must explain the potential risks of refusal to the caretaker on scene.
3. In the event that the legal guardian is not with the patient and transport is being refused, it is
   recommended that the legal guardian should be contacted
4. Always consider the possibility of abuse in these children
TAB 5 GUIDELINE 7
FOREIGN BODY AIRWAY OBSTRUCTION – CHILD

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS / SYMPTOMS</th>
<th>DIFFERENTIAL</th>
</tr>
</thead>
</table>
| • Events leading up to incident  
• Trauma  
• Aspiration  
• Medication  
• Allergic reaction | • Anxiety  
• No air movement  
• Clutching throat  
• Unresponsive  
• Sore throat, fever,  
• “Hot potato” voice, drooling | • Foreign Body  
• Infection  
• Cancer  
• Trauma  
• Laryngeal or tracheal fracture  
• Oropharyngeal laceration |

**LEGEND**

- Universal Patient Care
- Consider ALS Backup
- Signs of Airway Obstruction
- Conscious
- CHEST COMPRESSIONS
- Unresponsive
- Attempt breaths, if air does not enter retit head and reattempt breaths
- Check airway / perform finger sweep if see object
- Airway Obstruction Cleared
- PULSE
- NO
- Cardiac Arrest Guidelines
- Contact Medical Control
- Transport to appropriate facility

### Signs of Airway Obstruction

- Good air exchange
- Responsive and can cough forcefully
- May wheeze between coughs

### Severe Airway Obstruction Signs

- Poor or no air exchange
- Weak, ineffective cough or no cough at all
- High-pitched noise while inhaling or no noise at all
- Increased respiratory difficulty
- Possible cyanosis (turning blue)
- Unable to speak or move air
- Clutching the neck with the thumb and fingers
- Unresponsive
SPECIAL CONSIDERATIONS:

1. Use abdominal thrusts (the Heimlich maneuver) to relieve choking in children > 1 year of age. Give each individual thrust with the intent of relieving the obstruction. It may be necessary to repeat the thrust several times to clear the airway.

2. Choking victims initially may be responsive and then may become unresponsive. With a child choking victim who becomes unresponsive, open the airway, remove an object if you see it and begin CPR.

3. For a child victim, every time you open the airway to give breaths, open the victim’s mouth wide and look for the object. If you see an object, remove it with your fingers. If you do not see an object, keep doing CPR.

4. You can tell you have successfully removed an airway obstruction in the unresponsive victim if you:
   a. Feel air movement and see the chest rise when you give breaths
   b. See and remove a foreign body from the victim’s pharynx
TAB 5 GUIDELINE 8
FOREIGN BODY AIRWAY OBSTRUCTION – INFANT

**HISTORY**
- Events leading up to incident
- Trauma
- Aspiration
- Medication
- Allergic reaction

**SIGNS / SYMPTOMS**
- Anxiety
- No air movement
- Unresponsive
- Fever
- “Hot potato” voice, drooling

**DIFFERENTIAL**
- Foreign Body
- Infection
- Trauma
- Laryngeal or tracheal fracture
- Oropharyngeal laceration

---

**LEGEND**
- EMR
- EMT
- A-EMT
- EMT-P
- MC Order

---

**Universal Patient Care**
- Consider ALS Backup

**Conscious**

**Chest Compressions**
- Attempt breaths, if air does not enter retilt head and reattempt breaths

**Unresponsive**
- Perform (5) Back blows / (5) Chest Compression Manuever
- Airway Obstruction Cleared

**Check airway / perform finger sweep if see object**

**Airway Obstruction Cleared**

**Cardiac Arrest Guidelines**
- Contact Medical Control
- Transport to appropriate facility

---

**Mild Airway Obstruction Signs**
- Good air exchange
- Responsive and can cough forcefully
- May wheeze between coughs

**Severe Airway Obstruction Signs**
- Poor or no air exchange
- Weak, ineffective cough or no cough at all
- High-pitched noise while inhaling or no noise at all
- Increased respiratory difficulty
- Possible cyanosis (turning blue)
- Unable to cry or move air
- Unresponsive

---

**HISTORY**

**SIGNS / SYMPTOMS**

**DIFFERENTIAL**
SPECIAL CONSIDERATIONS:

1. Clearing an object from an infant’s airway requires a combination of back slaps and chest thrusts.
2. Do not perform blind finger sweeps in infants and children because the foreign body may be pushed back into the airway, causing further obstruction or injury.
3. If the victim becomes unresponsive, you will stop giving back slaps and will begin CPR. Chest compressions give effective pressure in the chest and may be able to relieve the obstruction.
## TAB 5 GUIDELINE 9

### HYPOTENSION (SHOCK)

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS / SYMPTOMS</th>
<th>DIFFERENTIAL</th>
</tr>
</thead>
</table>
| • < 16 years of age  
• Blood loss  
• Fluid loss  
  Vomiting  
  Diarrhea  
• Infection | • Restlessness, confusion, weakness  
• Dizziness  
• Increased HR, rapid pulse  
• Decreased BP  
• Pale, cool, clammy skin  
• Delayed capillary refill | • Trauma  
• Infection  
• Dehydration  
  Vomiting  
  Diarrhea  
• Fever  
• Congenital heart disease  
• Medication or Toxin |

### Universal Patient Care
- **Consider ALS Backup**

#### Evidence or History of Trauma

#### Check Blood Glucose
- **Glucose < 60**
  - **Oral Glucose**
    - 0.5 Gm / Kg PO
    - (Mental Status?)
  - **SBP < normal for age**
  - **Contact Medical Control**

- **NO**
  - **Glucose > 60**
    - **Place Supine Position**
    - **Contact ALS Backup**
    - **Consider ResQGARD**
      - (wgt > 25 pounds)
    - **Minimum Systolic BP by Age**
      - < 1 mo: 60 mmHg
      - 1 mo to 10 y: 70 + (2 × age in years)
      - ≥ 10 y: 90 mmHg

### LEGEND

- EMT
- EMT-P
- A-EMT
- EMR
- MC Order

### HISTORY
- • < 16 years of age  
- • Blood loss  
- • Fluid loss  
  Vomiting  
  Diarrhea  
• Infection

### SIGNS / SYMPTOMS
- • Restlessness, confusion, weakness  
- • Dizziness  
- • Increased HR, rapid pulse  
- • Decreased BP  
- • Pale, cool, clammy skin  
- • Delayed capillary refill

### DIFFERENTIAL
- • Trauma  
- • Infection  
- • Dehydration  
  Vomiting  
  Diarrhea  
• Fever  
• Congenital heart disease  
• Medication or Toxin

### Universal Patient Care
- **Consider ALS Backup**

#### Evidence or History of Trauma

#### Check Blood Glucose
- **Glucose < 60**
  - **Oral Glucose**
    - 0.5 Gm / Kg PO
    - (Mental Status?)
  - **SBP < normal for age**
  - **Contact Medical Control**

- **NO**
  - **Glucose > 60**
    - **Place Supine Position**
    - **Contact ALS Backup**
    - **Consider ResQGARD**
      - (wgt > 25 pounds)
    - **Minimum Systolic BP by Age**
      - < 1 mo: 60 mmHg
      - 1 mo to 10 y: 70 + (2 × age in years)
      - ≥ 10 y: 90 mmHg

### LEGEND

- EMT
- EMT-P
- A-EMT
- EMR
- MC Order

### HISTORY
- • < 16 years of age  
- • Blood loss  
- • Fluid loss  
  Vomiting  
  Diarrhea  
• Infection

### SIGNS / SYMPTOMS
- • Restlessness, confusion, weakness  
- • Dizziness  
- • Increased HR, rapid pulse  
- • Decreased BP  
- • Pale, cool, clammy skin  
- • Delayed capillary refill

### DIFFERENTIAL
- • Trauma  
- • Infection  
- • Dehydration  
  Vomiting  
  Diarrhea  
• Fever  
• Congenital heart disease  
• Medication or Toxin
Dispatch may receive calls requesting evaluation of an infant (<30 days old) who has been delivered by parent(s) to any fire or police station. (Pursuant to ORC 2152.3515 et. Seq., effective 03/24/2009 and local safety service entity agreement).

- EMS provider shall be dispatched to perform any evaluation or intervention necessary to protect the infant’s health or safety, and
- Transport the child to the closest appropriate hospital emergency department.

**Emergency Medical Services Workers Obligations to Whom a Child which is Less Than 30 Days Old is Delivered (ORC 2151.3515 et.seq. Effective 03/24/2009)**

While acting in their official capacity an **EMS provider** (EMR, EMT, AEMT or Paramedic) on behalf of the Emergency Services Organization (as defined by 4765.01) that employs the worker or for which the worker provides services, **shall take possession** of a child who is seventy-two hours old or younger if that child’s **parent** has **voluntarily delivered** the child to that person without the parent expressing an intent to return for the child.

**Upon taking possession of the child, the Emergency Services Organization shall do all of the following:**

1. Perform any act necessary to protect the child’s health or safety;
2. Notify EMS Dispatch that the child has been taken into possession;
3. When forms developed by the Ohio Department of Jobs and Family Service (ODJFS) are available designed to gather medical information concerning the child and the child’s parents, provide such to surrendering parent;
4. If available, offer written materials developed by ODJFS that describe services available to assist parents and newborns;
5. Only if the child appears to have a condition which reasonably indicates physical or mental abuse or neglect-attempt to identify and, if necessary, pursue the person who delivered the child;
EMS Workers Shall Not:

1. Coerce or otherwise try to force the caregiver into revealing the identity of the child’s parents;
2. Pursue or follow the caregiver after the caregiver leaves the place at which the child was delivered;
3. Coerce or otherwise try to force the caregiver / parent not to desert the child;
4. Coerce or otherwise try to force the caregiver / parent to accept the medical information forms promulgated by the ODJFS;
5. Coerce or otherwise try to force caregiver / parent to accept materials promulgated by the ODJFS;

Items (1) and (2) above do not apply to a person who delivers or attempts to deliver a child who has suffered any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child.
**TAB 5 GUIDELINE 11**

**POISONING | OVERDOSE | TOXIC INGESTION**

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS / SYMPTOMS</th>
<th>DIFFERENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• &lt; 16 years of age &lt;br&gt; • Ingestion or suspected ingestion of a potentially toxic substance &lt;br&gt; • Substance ingested, route, quantity &lt;br&gt; • Time of ingestion &lt;br&gt; • Reason (suicidal, accidental, criminal) &lt;br&gt; • Available medication in home &lt;br&gt; • Past medical history, medications</td>
<td>• Mental status changes &lt;br&gt; • Hypotension / Hypertension &lt;br&gt; • Decreased respiratory rate &lt;br&gt; • Tachycardia, dysrhythmias &lt;br&gt; • Seizures</td>
<td>• Tricyclic antidepressants (TCAs) &lt;br&gt; • Acetaminophen (Tylenol) &lt;br&gt; • Depressants &lt;br&gt; • Stimulants &lt;br&gt; • Anticholinergic &lt;br&gt; • Cardiac medications &lt;br&gt; • Solvents, alcohols, cleaning agents &lt;br&gt; • Insecticides (organophosphates)</td>
</tr>
</tbody>
</table>

---

**LEGEND**

- EMT
- EMT-P
- MC Order
- A-EMT
- EMR

**Universal Patient Care**

- Consider ALS Backup

**Poisoning**

- **Altered Mental Status**
  - Blood Sugar < 60 mg / dl
  - Respiratory Depression

- **CO Poisoning**

- **Organophosphate / Nerve Agent**

- **Other**

**Contact Medical Control**

- **Transport to appropriate facility**

**Minimum Systolic BP by Age**

- < 1 mo: 60 mmHg
- 1 mo to 10 y: 70 + (2 × age in years)
- ≥ 10 y: 90 mmHg

**Appropriate Guideline**

**Oral Glucose**

- 0.5 Gm / Kg PO
  - (Mental Status?)

**Naloxone**

- 0.1 mg / Kg IN
  - (with respiratory depression)

**CO**

- **NRB Mask @ 15 L O2**
- **CPAP with PEEP @ 5 cm H2O**

**Duodote**

- IM 1 – 3 injectors
  - (Age > 14 or > 40 Kg)
SPECIAL CONSIDERATIONS:

1. General:
   a. Improve the care of patients with poisonings, and environmental/biochemical terrorism exposures in the pre-hospital setting. Provide for the most timely and appropriate level of care to the patient, including the decision to transport or treat on the scene.
   b. If no immediate life threat or need for transport is identified, EMS personnel may conference the patient/caller with the Poison Center Specialist at the Poison Control Center at 800-222-1222.
      i. The Poison Center Specialist at the State Poison Center will evaluate the exposure and make recommendations regarding the need for on-site treatment and/or hospital transport in a timely manner.
      ii. If the patient is determined to need EMS transport, the poison control center Specialist will contact the receiving hospital and provide information regarding the poisoning, including treatment recommendations. EMS may contact medical control for further instructions or to discuss transport options.
      iii. If the patient is determined not to require EMS transport, personnel will give the phone number of the patient/caller to the Poison Center Specialist. The Specialist will initiate a minimum of one follow-up call to the patient/caller to determine the status of patient.
      iv. Minimal information that should be obtained from the patient for the state poison center includes:
         - Name and age of patient
         - Substance(s) involved
         - Time of exposure
         - Any treatment given
         - Signs and symptoms
      v. Minimal information which should be provided to the State Poison Center for mass poisonings, including biochemical terrorism and HazMat, includes:
         - Substance(s) involved
         - Time exposure
         - Signs and symptoms
         - Any treatment given
   c. Do not induce vomiting for
      - Hydrocarbons
      - Strong Acids
      - Strong Base Iodides
      - Silver Nitrate
      - Strychnine
      - Who are not alert
   d. Do not neutralize acids with alkali or Do not neutralize alkali with acids
   e. Product labels and home kits may be misleading and dangerous
f. All empty containers of ingested material should accompany patient to the hospital

g. Do not rely on patient history of ingestion, especially in suicide attempts

2. Overdose / Ingestion concerns:

a. **Acetaminophen** – Initial presentation normal or nausea/vomiting. If not detected and treated, will cause irreversible liver failure

b. **Anticholinergic** – increased HR, increased temperature, dilated pupils, mental status changes

c. **Cardiac Meds** – dysrhythmias and mental status changes

d. **Depressants** – decreased HR, decreased BP, decreased temperature, decreased respirations, non-specific pupils

e. **Insecticides** – increased or decreased HR, increased secretions, nausea, vomiting, diarrhea, pinpoint pupils

f. **Solvents** – nausea, vomiting, and mental status changes

g. **Stimulants** – increased HR increased BP, increased temperature, dilated pupils, and seizures

h. **Tricyclics** – 4 major areas of toxicity: seizures; dysrhythmias; hypotension; decreased mental status or coma; rapid progression from alert mental status to death

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| Carbon Monoxide | • Carbon monoxide is produced from a variety of sources such as vehicles, gasoline engines, camp stoves, lanterns, burning charcoal and wood, gas ranges, heating systems and poorly vented chimneys. Structural fires are another common source of CO exposure.  
• Normal Carbon Monoxide Levels  
  • 1 – 2 %  
• Factors which may reduce the reliability of carbon monoxide readings:  
  • Poor peripheral circulation (hypovolemia, hypotension, hypothermia).  
  • Excessive sensor motion.  
  • Fingernail polish (may be removed with finger nail polish remover).  
  • Irregular heart rhythms (atrial fibrillation, SVT, etc.).  
  • Jaundice. |
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
</table>
| **Cyanide**    | • Any smoke inhalation victim with mental status changes should also be treated for Cyanide Poisoning if medication is available, or if known exposure to Cyanide. Any patient or firefighter that goes into cardiac arrest after exposure to smoke from a fire.  
  • Present history: when last well, progression of present state, prior symptoms such as increase in respirations, convulsions, coma.  
  • Check for bottles and read ingredient label. If patient is in an industrial setting, ask if they use Cyanide.  
  • Principal manifestations of poisoning with these compounds are rapid respirations, blood pressure fall, convulsions and coma; may also cause lightheadedness, vomiting, flushing, headache, drowsiness, hypotension, rapid pulse and unconsciousness.  
  • Check for odor of “BITTER ALMONDS”.                                                                 |
| **Hydrofluoric Acid** | • EMT should continue the therapy initiated by previous EMS providers in regards to dermal or inhalation therapy of Calcium Gluconate.                                                                 |
| **Nerve Agent Exposure / Organophosphate Poisoning** | • **Mild symptoms:**  
  • 1 Duodote  
  • **Moderate:** Unable to ambulate but still conscious  
  • 1 Duodote  
  • **Severe:** Unconscious / seizures  
  • 3 Duodote  

**Do not administer more than three (3) DuoDote Auto-Injectors or three (3) Mark 1 Kits** unless definitive medical care is available. The limit of 3 doses is specific to the pralidoxime component of the DuoDote and Mark 1 Kit. **If necessary, additional doses of atropine can be administered if the 3 doses of DuoDote or Mark 1 Kit injections do not produce an adequate response.**
POISONING | OVERDOSE | OPIATE

**HISTORY**
- What type of ingestion
- When did ingestion occur
- How Much
- Reason for ingestion
- Actions of bystanders
- Previous psychiatric disorders
- Diseases / Medications: ie depressants
- Medical alert tags

**SIGNS / SYMPTOMS**
- Increased salivation
- Soot or burns in mouth
- Irritation of the eyes
- Sweating and skin burns
- Decreased respiratory rate
- Lung findings (ie edema)
- Delayed capillary refill
- Tachycardia / Arrhythmias
- Seizures

**ENVIRONMENT**
- Acetaminophen
- Anticholinergic
- Aspirin
- Cardiac medications
- Insecticides (organophosphates)
- Solvents, alcohols, cleaning agents
- Stimulants

---

**Universal Patient Care**
- Consider ALS Backup
- Exposure control
  (PPE = Non-Porous Gloves / Eye Protection / N95 Mask / Gown)
- Ensure crew safety
  Avoid evidence tampering

**Respiratory Rate ≤ 12**
- YES
  - Position of patient comfort
  - Appropriate Guideline
- NO

**Check Blood Glucose**
- Glucose ≤ 60

**Altered Mental Status**
- Presumed Opiate Overdose
  - Respiratory Rate ≤ 8

**Contact Medical Control**
- Transport to appropriate facility
- Decontaminate Ambulance and Equipment after Transport

**Oral Glucose**
- 0.5 Gm / Kg PO
  (Mental Status?)

**Naloxone**
- 0.1 mg / Kg IN
  (administer max dose 0.5 mg / dose every 1 – 2 minutes)

**Minimum Systolic BP by Age**
- < 1 mo: 60 mmHg
- 1 mo to 10 y: 70 + (2 × age in years)
- ≥ 10 y: 90 mmHg
SPECIAL CONSIDERATIONS:

1. The main focus for treatment is to ensure proper respiratory and oxygen saturation status. The goal is “NOT TO WAKE” the patient up. Naloxone administration should be at no more than 0.5 mg aliquots every 1 – 2 minutes. While naloxone is being administered ensure that proper ventilation is being performed with bag-valve mask and oxygen.

2. All suspected patients with opiate overdose should be handled using non-porous type gloves (nitrile style, non-latex) and eye protection. Consider wearing N-95 mask and gowns for any patient that has visible powder on body, or if there is visible powder in patient care area.

3. Vehicle and Equipment Decontamination
   a. Any concern for opiate contamination within the vehicle or on the equipment should be cleaned using N95 mask with non-porous type gloves (nitrile style, non-latex) and eye protection.
   b. Spill Clean Up Instructions
      i. Wear appropriate PPE
      ii. Add one teaspoon full of powder OxiClean™ to 500 mL water
      iii. Shake gently until all powder is in solution
      iv. Completely cover spill with spray
      v. Within 15 minutes, scrub with a paper towel until dry (solution evaporates over time and this decreases the effectiveness of decontamination)
      vi. All PPE (except goggles) and paper towels must be disposed of in a biohazardous waste bin.
### TAB 5 GUIDELINE 13
#### PSYCHIATRIC PATIENT

#### HISTORY
- Situational crisis
- Psychiatric illness / medications
- Injury to self or threats to others
- Medic alert tag
- Substance abuse / overdose
- Diabetes

#### SIGNS / SYMPTOMS
- Anxiety, agitation, confusion
- Affect change, hallucinations
- Delusional thoughts, bizarre behavior
- Expression of suicidal / homicidal thoughts
- Poor concentration, easily distracted, psychosis
- Combative, violent

#### DIFFERENTIAL
- See Altered Mental Status differential
- Hypoxia
- Alcohol intoxication
- Medication effect / overdose
- Withdrawal syndromes
- Depression
- Bipolar (manic-depressive)
- Schizophrenia, anxiety disorders, etc.

---

**Legend**
- EMT
- EMT-P
- MC Order
- A-EMT
- EMR

---

#### Universal Patient Care
Consider ALS Back-Up

- Remove patient from stressful environment

---

#### Behavioral | Excited Delirium
Guideline

---

#### Patient Agitated / Aggressive

---

#### Patient having anxiety attack

---

#### Patient Depressed / Suicidal / Homicidal

---

#### Verbal techniques
(reassurance, calm, establish rapport)

---

#### Rapid take-down w/ minimum (4) EMS crew members
(If necessary)

---

#### Consider Use of Restraints
(for patient / personnel safety)

---

#### Oral Glucose
0.5 Gm / Kg PO (Mental Status?)

---

#### Glucose ≤ 60

---

#### Check Blood Glucose

---

#### Contact Medical Control
Transport to appropriate facility

---

#### Minimum Systolic BP by Age
- `< 1 mo: 60 mmHg`
- `1 mo to 10 y: 70 + (2 × age in years)`
- `≥ 10 y: 90 mmHg`

---

**Consider Mental Health Hold (Pink Slip)**

---

**Restraints**
- No transport in hobble or prone position.
- Do not inhibit patient breathing, ventilations
# TAB 5 GUIDELINE 14
## RESPIRATORY DISTRESS

### HISTORY
- < 16 years of age
- Time of onset
- Possibility of foreign body
- Medical history
- Medications
- Fever or respiratory infection
- Other sick siblings
- History of trauma

### SIGNS / SYMPTOMS
- Wheezing or stridor
- Respiratory retractions
- Increased heart rate
- Altered level of consciousness
- Anxious appearance

### DIFFERENTIAL
- Asthma
- Aspiration
- Foreign body
- Infection
  - Pneumonia
  - Croup
  - Epiglottitis
  - Congenital heart disease
  - Medication or toxin
  - Trauma

### LEGEND
- EMR
- EMT
- A-EMT
- EMT-P
- MC Order
- Universal Patient Care
- Consider ALS Backup
- Respiratory Insufficiency
- Position of patient comfort

### Airway Management
- YES

### Pulse Oximetry
- NO

### Wheezing
- Age < 18 months with 1st wheeze

#### Albuterol
- 1.25 mg nebulized
  - Wgt < 10 Kg
- 2.5 mg nebulized
  - (May repeat x 2)
  - Wgt > 10 Kg

### Wheezing
- Age > 18 months or history of wheeze

#### Albuterol
- 2.5 mg nebulized
  - (May repeat x 2)
  - Wgt > 10 Kg

### Stridor / Croup

#### Severe symptoms
- Stridor at rest
- Severe retractions
- Cyanosis
- Altered LOC

### Minimum Systolic BP by Age
- < 1 mo: 60 mmHg
- 1 mo to 10 y: 70 + (2 × age in years)
- ≥ 10 y: 90 mmHg

### Contact Medical Control
- Transport to appropriate facility

---

**HISTORY**
- < 16 years of age
- Time of onset
- Possibility of foreign body
- Medical history
- Medications
- Fever or respiratory infection
- Other sick siblings
- History of trauma

**SIGNS / SYMPTOMS**
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- Asthma
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  - Medication or toxin
  - Trauma

---

**LEGEND**
- EMR
- EMT
- A-EMT
- EMT-P
- MC Order

---

**空气管理**
- YES

**脉搏血氧仪**
- NO

**哮喘**
- 年龄 < 18 个月且首次喘鸣

#### 舒喘灵
- 1.25 mg 肺部吸入
  - 体重 < 10 Kg
- 2.5 mg 肺部吸入
  - （可重复 x 2）
  - 体重 > 10 Kg

**哮喘**
- 年龄 > 18 个月或有喘鸣史

#### 舒喘灵
- 2.5 mg 肺部吸入
  - （可重复 x 2）
  - 体重 > 10 Kg

**嘶哑 / 气管炎**

#### 严重症状
- 嗓音中断
- 严重收缩
- 蓝色
- 认知障碍

---

**最低收缩压根据年龄**
- < 1 月: 60 mmHg
- 1 月至 10 年: 70 + (2 × 年龄 in years)
- ≥ 10 年: 90 mmHg

---

**紧急联系**
- 转诊至合适设施

---

## TAB 5 GUIDELINE 14
### RESPIRATORY DISTRESS

### HISTORY
- < 16 years of age
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- Medical history
- Medications
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- Other sick siblings
- History of trauma

### SIGNS / SYMPTOMS
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- Anxious appearance

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- Aspiration
- Foreign body
- Infection
  - Pneumonia
  - Croup
  - Epiglottitis
  - Congenital heart disease
  - Medication or toxin
  - Trauma

### LEGEND
- EMR
- EMT
- A-EMT
- EMT-P
- MC Order

---

**空气管理**
- YES

**脉搏血氧仪**
- NO

**哮喘**
- 年龄 < 18 个月且首次喘鸣

#### 舒喘灵
- 1.25 mg 肺部吸入
  - 体重 < 10 Kg
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  - 体重 > 10 Kg

**哮喘**
- 年龄 > 18 个月或有喘鸣史

#### 舒喘灵
- 2.5 mg 肺部吸入
  - （可重复 x 2）
  - 体重 > 10 Kg

**嘶哑 / 气管炎**

#### 严重症状
- 嗓音中断
- 严重收缩
- 蓝色
- 认知障碍

---

**最低收缩压根据年龄**
- < 1 月: 60 mmHg
- 1 月至 10 年: 70 + (2 × 年龄 in years)
- ≥ 10 年: 90 mmHg

---

**紧急联系**
- 转诊至合适设施

---

## TAB 5 GUIDELINE 14
### RESPIRATORY DISTRESS

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### LEGEND
- EMR
- EMT
- A-EMT
- EMT-P
- MC Order

---

**空气管理**
- YES

**脉搏血氧仪**
- NO

**哮喘**
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#### 舒喘灵
- 2.5 mg 肺部吸入
  - （可重复 x 2）
  - 体重 > 10 Kg

**嘶哑 / 气管炎**

#### 严重症状
- 嗓音中断
- 严重收缩
- 蓝色
- 认知障碍

---

**最低收缩压根据年龄**
- < 1 月: 60 mmHg
- 1 月至 10 年: 70 + (2 × 年龄 in years)
- ≥ 10 年: 90 mmHg

---

**紧急联系**
- 转诊至合适设施
SPECIAL CONSIDERATIONS:

1. Do not force a child into a position. They will protect their airway by their body position.

2. Upper airway obstruction and stridor are usually due to croup, viral disease with inflammation, edema, or narrowing of the larynx, trachea or bronchioles. Croup usually affects infants and toddlers (< 2 years of age). Most children with croup present with a history of cold-type symptoms followed by the development of a barking or “seal” cough, stridor and various levels of respiratory distress. Many times, accompanied by a low-grade fever, the symptoms of croup often worsen during the night-time hours. The severity of symptoms will vary widely among patients.

3. Wheezing is the hallmark of lower airway obstruction. Decreased unequal or absent breath sounds also can occur. The respiratory rate is generally rapid (although when expiration becomes prolonged, the rate may fall). Bronchiolitis, asthma, and foreign body obstruction should be strongly considered. Bronchiolitis is a lower airway obstruction from viral illness with wheezing in the toddler or infant under the age of 2 years. Asthma or foreign body inhalation can also cause similar symptoms. Bronchiolitis may not respond to Albuterol due to lower airway swelling from the infection.

4. With respiratory distress of sudden onset, think of foreign body airway aspiration. The mouth is a major sensory organ for children. The EMS provider must anticipate infants and children placing a multitude of obstructive hazards in their airway.

5. Epiglottitis typically affects children > 2 years of age. It is bacterial, with fever, rapid onset, possible stridor, patient wants to sit up to keep airway open, and drooling is common. Airway manipulation and patient agitation may lead to total airway obstruction and worsening of the patient’s condition.

6. If children with croup, Epiglottitis or laryngeal edema present in respiratory arrest, it is usually due to exhaustion or airway obstruction. Ventilation by bag-valve mask may be difficult due to airway edema. Epiglottitis and croup can become total airway obstructions very quickly.
### TAB 5 GUIDELINE 15
#### SEIZURE

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS / SYMPTOMS</th>
<th>DIFFERENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age</td>
<td>• Observed seizure activity</td>
<td>• Infection / Fever</td>
</tr>
<tr>
<td>• Fever</td>
<td>• Altered mental status</td>
<td>• Head trauma</td>
</tr>
<tr>
<td>• Prior history of seizures</td>
<td>• Hot, dry skin or elevated body temperature</td>
<td>• Medication or toxin</td>
</tr>
<tr>
<td>• Seizure medications</td>
<td>• Sleepiness</td>
<td>• Hypoxia or respiratory failure</td>
</tr>
<tr>
<td>• Reported seizure activity</td>
<td>• Incontinence</td>
<td>• Electrolyte abnormality (Na, Ca, Mg)</td>
</tr>
<tr>
<td>• History of recent head trauma</td>
<td>• Evidence of trauma</td>
<td>• Drugs, medications, non-compliance</td>
</tr>
<tr>
<td>• Congenital abnormality</td>
<td>• Unconsciousness</td>
<td>• Hyperthermia / Hypoglycemia</td>
</tr>
</tbody>
</table>

**SIGNS / SYMPTOMS**
- Observed seizure activity
- Altered mental status
- Hot, dry skin or elevated body temperature
- Sleepiness
- Incontinence
- Evidence of trauma
- Unconsciousness

**DIFFERENTIAL**
- Infection / Fever
- Head trauma
- Medication or toxin
- Hypoxia or respiratory failure
- Electrolyte abnormality (Na, Ca, Mg)
- Drugs, medications, non-compliance
- Hyperthermia / Hypoglycemia
- Metabolic abnormality / acidosis
- Tumor

### LEGEND
- EMR
- EMT
- A-EMT
- EMT-P
- MC Order

### FLOWCHART

1. **Universal Patient Care**
   - Consider ALS Backup

2. **Consider Spinal Immobilization**
   - Airway Management
   - Check Blood Glucose

3. **Febrile**
   - Tympanic temperature measurement
   - **NO**
   - **YES**
     - Cooling Measures
     - Cardiac Monitor / 12-Lead EKG

4. **Active Seizure**
   - **NO**
   - **YES**

5. **Focused History / Physical Exam**
   - Evidence of shock or trauma?
   - Appropriate Guideline

6. **Contact Medical Control**
   - Transport to appropriate facility

7. **Minimum Systolic BP by Age**
   - < 1 mo: 60 mmHg
   - 1 mo to 10 y: 70 + (2 x age in years)
   - ≥ 10 y: 90 mmHg
SPECIAL CONSIDERATIONS:

1. If actively seizing patient is encountered, move hazardous material away from the patient. Protect the patient’s head from injury. Remember to always immediately check for pulses after seizure activity stops.

2. Trauma to the tongue during seizure activity is unlikely to cause serious problems. Attempt to force anything into the patient’s airway may cause complete obstruction.

3. If febrile, remove clothing and sponge with room temperature water. Do not delay transport for cooling measures. Removal of clothing may be all that is necessary.

4. Unlike the adult with a diagnosis of Epilepsy, a child who has had a seizure usually requires transport. Do not be falsely reassured by a child who appears to return to normal status quickly.

5. Seizures in children may not always present tonic-clonic (generalized) in nature. Unusual gaze/eye movement, unresponsiveness, or localized twitching may be the only clue. Parents or caregivers are usually very sensitive to the abnormality and potential seriousness of the child’s presentation.

6. The diagnosis of “febrile seizures” can be difficult to make in the field. Other causes must be excluded. Temperature measurements (tympanic thermometer) should be acquired with suspicion of fever.

7. Status epilepticus is defined as two or more successive seizures without a period of consciousness or recovery. This is a true emergency requiring rapid airway control, treatment, and transport. Grand Mal seizures (generalized) are associated with loss of consciousness, incontinence, and tongue trauma. Focal seizures (petit mal) effect only a part of the body and are not usually associated with a loss of consciousness. Jacksonian seizures are seizures that start as a focal seizure and become generalized.

8. If evidence or suspicion of trauma, full c-spine immobilization is required.
TAB 5 GUIDELINE 16
SUSPECTED ABUSE | NEGLECT

**HISTORY**
- Events leading up to call
- Has individual gone to the bathroom, showered
- History of trauma

**SIGNS / SYMPTOMS**
- Bruising to extremities
- Vaginal injury
- Withdrawal from caregiver / EMS provider

**DIFFERENTIAL**
- Sexual abuse
- Neglect
- Traumatic injuries

---

**Universal Patient Care**
- Ensure scene safety and offender is not near the victim

**Consider Spinal Immobilization**
- Airway Management

**Minimum Systolic BP by Age**
- < 1 mo: 60 mmHg
- 1 mo to 10 y: 70 + (2 × age in years)
- ≥ 10 y: 90 mmHg

**Concern to Physical Abuse**
- Make Patient NPO
- Assess for psychological characteristics of abuse
- Assess for physical abuse
- Assess for signs of neglect

**Concern to Sexual Abuse**
- Make Patient NPO
- Discourage patient going to bathroom
- Don’t allow patient to change clothes or wash

**Document careful physical exam and any comments made by victim, family, bystanders**

**Contact Medical Control**
- Transport to appropriate facility, severely injured patients should be transported to trauma center
- Report suspected case of child abuse, neglect or exploitation to Children Services (855-642-4453)

**To Be Transported to Trauma Center**
- Stabbing
- Choking
- Electrocution
- Burn

---

**Legend**
- EMR
- EMT
- A-EMT
- EMT-P
- MC Order
SPECIAL CONSIDERATIONS:

1. Reporting concern of abuse, neglect or exploitation
   a. Per Ohio Revised Codes (ORC) 2151.421 and 5101.61 EMS and Fire personnel are **REQUIRED** to report abuse, neglect or exploitation of adult (elderly) or child (under the age of 18)
   b. Report suspected child abuse, neglect or exploitation to Ohio’s Public Children Service Agencies for your respective county or free hotline at 855-642-4453
   c. Report suspected elderly abuse, neglect or exploitation to Ohio’s Adult Protective Services for your respective county or free hotline at 855-644-6277

2. If possible, have a witness the same gender as the victim present at all times

3. Wrap a plastic sheet around the victim if possible

4. **DO NOT** inspect genitals unless evidence of uncontrolled hemorrhage, trauma, or severe pain is present

5. **DO NOT** allow patient to shower or douche

6. Collect patient’s clothing when possible
   a. Place clothing in plastic sheet or separate plastic/paper bags with ID labels and found location
   b. Leave all sheets placed in plastic/paper bag with patient at facility
   c. Notify all staff of clothing samples
TAB 5 GUIDELINE 17
VOMITING AND DIARRHEA

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS / SYMPTOMS</th>
<th>DIFFERENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age &lt; 16</td>
<td>• Pain</td>
<td>• CNS</td>
</tr>
<tr>
<td>• Time of last meal</td>
<td>• Character of pain</td>
<td>• Myocardial infarction</td>
</tr>
<tr>
<td>• Last bowel movement/emesis</td>
<td>• Distention</td>
<td>• Drugs (NSAID’s, antibiotics, narcotics, chemotherapy)</td>
</tr>
<tr>
<td>• Improvement or worsening with food or activity</td>
<td>• Constipation</td>
<td>• GI or renal disorders</td>
</tr>
<tr>
<td>• Duration of problem</td>
<td>• Diarrhea</td>
<td>• Diabetic ketoacidosis</td>
</tr>
<tr>
<td>• Other sick contacts</td>
<td>• Anorexia</td>
<td>• Gynecologic disease</td>
</tr>
<tr>
<td>• Past medical history</td>
<td>• Radiation</td>
<td>• Infections (pneumonia, influenza)</td>
</tr>
<tr>
<td>• Medications</td>
<td></td>
<td>• Electrolyte abnormalities</td>
</tr>
<tr>
<td>• Menstrual history (pregnancy)</td>
<td></td>
<td>• food or toxin induced</td>
</tr>
<tr>
<td>• Travel history</td>
<td></td>
<td>• Medication or substance abuse</td>
</tr>
<tr>
<td>• Bloody emesis / diarrhea</td>
<td><strong>Associated symptoms:</strong> (Helpful to localize source)</td>
<td>• Pregnancy</td>
</tr>
<tr>
<td></td>
<td>Fever, headache, blurred vision, weakness, malaise, cough, headache, dysuria, mental status changes, rash</td>
<td>• Psychological</td>
</tr>
</tbody>
</table>

**LEGEND**
- EMT
- EMT-P
- MC Order
- EMR

**Universal Patient Care**
- Consider ALS Backup
- Make NPO

**Check Blood Glucose**
- Glucose ≤ 60

**Hypotension**
- Place Supine Position
- Contact ALS Backup
- Contact Medical Control
- Transport to appropriate facility

**Oral Glucose**
- 0.5 Gm / Kg PO
- (Mental Status?)

**Minimum Systolic BP by Age**
- < 1 mo: 60 mmHg
- 1 mo to 10 y: 70 + (2 × age in years)
- ≥ 10 y: 90 mmHg

**SPECIAL CONSIDERATIONS:**
1. Complete assessment and physical exam including evaluation of mental status, skin, HEENT, neck, heart, lungs, abdomen, back, extremities and neuro.
2. Frequent re-assessments are needed to monitor vascular status.
TAB 5 GUIDELINE 18
CHILDREN WITH SPECIAL HEALTHCARE NEEDS

1. EMS providers are encouraged to know which children in a given area have special needs and to keep a logbook for potential problems related to these children.
   - This will allow for easier reference and treatment for the patient.
2. Parents and caretakers are usually trained in emergency management and can be of assistance to EMS personnel. Listen carefully to the caregiver and follow his / her guidance regarding the child’s treatment.
3. Treat the ABC’s first. Treat the child, not the equipment. If the emergency is due to an equipment malfunction, manage the child appropriately using your own equipment.
4. Children formerly cared for in hospitals or chronic care facilities are often cared for in homes by parents or other caretakers. These children may have self-limiting or chronic diseases.
   - There are multitudes of underlying medical conditions that may categorize children as having special needs.
   - Many are often unstable and may frequently involve the EMS system for evaluation, stabilization, and transport.
   - Special needs children include technology-assisted children such as those with tracheostomy tubes with or without assisted ventilation, children with gastrostomy tubes, and children with indwelling central lines. The most serious complications are related to tracheostomy problems.
5. Children with Special Healthcare Needs (CSHCN) have many allergies.
   - Children with spina bifida are often allergic to latex. Before treating a patient, ask the caregivers if the children are allergic to latex or have any other allergies. Stock latex-free equipment. (Some regularly used equipment that contains latex includes gloves, oxygen masks, IV tubing BVM, blood pressure cuff, IV catheters, etc.)
6. Children with chronic illnesses often have different physical development from well children.
   - Their baseline vital signs may differ from normal standards. Ask the caregiver if the child normally has abnormal vital signs. (i.e. a fast heart rate or a low pulse oximeter reading)
   - The size and developmental level may be different from age-based norms and length based tapes used to calculate drug dosages.
7. Some CSHCN may have sensory deficits (i.e. they may be hearing impaired or blind) yet may have age-appropriate cognitive abilities. Follow the caregivers’ lead in talking to and comforting a child during treatment and transport. Do not assume that a CSHCN is developmentally delayed.
8. When moving a special needs child, a slow careful transfer with two or more people is preferable. Do not try to straighten or unnecessarily manipulate contracted extremities as it may cause injury or pain to the child. Certain medical conditions will require special care. Again, consult the child’s caregiver.

9. Caregivers of CSHCN often carry “go bags” or diaper bags that contain supplies to use with the child’s medical technologies and additional equipment such as extra tracheostomy tubes, adapters for feeding tubes, suction catheters, etc. Before leaving the scene, ask the caregivers if they have a “go bag” and carry it with you.

10. Caregivers may also carry a brief medical information form or card. The child may be enrolled in a medical alert program whereby emergency personnel can get quick access to the child’s medical history. Ask the caregivers if they have an emergency information form or some other form of medical information for their child.

11. Caregivers of CSHCN often prefer that their child be transported to the hospital where the child is regularly followed or the “home” hospital. When making the decision as to where to transport a CSHCN, take into account: local protocols, the child’s condition, capabilities of the local hospital, caregivers’ request, ability to transport to certain locations.