

ABUSE - PEDIATRIC

EMT/AEMT/PARAMEDIC:

- 1) Findings suspicious of child abuse:
 - A) Explanations of mechanisms of injury conflicting with actual injury.
 - B) Cigarette bums; belt marks; multiple bruises of varied age.
 - C) History of repeated injuries.
 - D) Blame placed upon others.
 - E) Procrastination by caretaker in seeking aid.
 - F) Sexual abuse may be present without signs of apparent physical abuse.
- 2) Treat injuries per appropriate trauma protocol.
- 3) Carefully document caretaker's description of event(s).
- 4) Observe carefully and note:
 - A) Environment.
 - B) Reaction of all adults.
 - C) Patient's clothing, stains, conditions. Bring clothing in with patient.
- 5) Support and reassure child. Be non-judgmental and supportive to family concerns.
- 6) Encourage caretaker to allow transport of child to hospital for medical evaluation and/or treatment. If they do not agree, contact Law Enforcement or Child Protective Services.

(End)

AIRWAY OBSTRUCTION BY FOREIGN BODY - PEDIATRIC

CONSCIOUS PATIENT ABLE TO SPEAK, COUGH, OR CRY

EMT/AEMT/PARAMEDIC:

- 1) Reassure patient.
- 2) Allow patient to assume position of maximal comfort, with parent if necessary.
- 3) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed
- 4) Suction as needed.

CONSCIOUS PATIENT UNABLE TO SPEAK, COUGH OR CRY:

EMT:

- 1) **INFANT:** Deliver back blows and chest thrusts.
- 2) **CHILD:** Deliver Abdominal Thrusts.
- 3) Reassess airway, repeating step 1 until clear.
- 4) Allow patient to assume position of maximal comfort, with parent if necessary.
- 5) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed
- 6) If patient becomes unconscious:
 - A) Quickly visualize upper airway.
 - B) Attempt ventilations.
 - C) If unsuccessful, repeat steps 1 and 2.

AEMT:

As above

- 7) If patient < 2 and unable to ventilate, continue vigorous attempts to clear airway and transport ASAP.

PARAMEDIC:

As above

- 8) If unsuccessful, visualize airway using laryngoscope and McGill forceps.
- 9) If patient > 2 and unable to ventilate, consider **needle cricothyroidotomy**

(End)

**ALTERED LEVEL OF CONSCIOUSNESS/COMA OF UNKNOWN ORIGIN -
PEDIATRIC**

EMT:

- 1) Establish and secure airway. Consider obstructed airway and/or inadequate ventilations as a cause of ALOC.
- 2) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed
- 3) Check blood glucose
- 4) Consider causes of coma AEIOU-TIPS*.
- 5) Consider Calling for ALS
- 6) Transport ASAP.

AEMT:

As above

- 7) **Isotonic Solution IV/IO TKO.** If signs of shock present, administer 20 ml/kg fluid challenge as rapidly as possible. Repeat X 1 minimum BP for age and clinical improvement (capillary refill < 2 sec., stronger pulses, warmer extremities, improving LOC).
- 8) If capillary blood glucose < 60,
 - A) **2.0-4ml/kg D25W IV/IO push.** If patient < 1 year, dilute 1:1 with NS.
 - B) **Glucagon 1.0 mg IM** if unable to establish IV/IO.
- 9) **Narcan 0.1 mg/kg IV/IO/IM **** Max dose of 2.0 mg.

PARAMEDIC:

As above

- 10) If King airway in place / attach end tidal CO2 monitoring (confirm oxygenation & ventilation) if not Intubate Patient if patient respirations are < 8 per minute.

*[A] - Alcohol, Acidosis

[E]- Epilepsy

[I] - Infection

[O] - Overdose/Poisoning

[U] - Uremia

[T] - Trauma

[I] - Insulin

[P] - Psychosis

[S] - Stroke

** This drug may be given via the endotracheal tube if an IV cannot be established. The ET dose is double the IV dose.

(End)

ANAPHYLAXIS - PEDIATRIC

MILD: Red, itchy skin; hives; and, if sting present, localized swelling at sting site; vital signs within normal limits.

EMT:

- 1) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed.
- 2) If present, scrape stinger out. Stabilize involved extremity and apply ice.
- 3) Apply restrictive band on involved extremity above injection or sting site, if present.
- 4) Transport ASAP

AEMT:

As above

- 5) **Isotonic Solution IV TKO**

PARAMEDIC:

As above

- 6) Cardiac monitor
- 7) **Benadryl 1.0 mg/kg IM** up to a maximum of 50 mg.

MODERATE: As above and swelling of face, lips, tongue, or pharynx; mild to moderate SOB; wheezing; BP > 90.

EMT/ AEMT:

- 1) Follow steps 1-4 for mild anaphylaxis.
- 2) **EPI Pen** if available.
- 3) **Epinephrine 1:1,000, 0.01 mg/kg IM** up to a maximum dose of 0.5 mg. Repeat q 5 min., as needed.

PARAMEDIC:

As above

- 4) Cardiac monitor
- 5) **Benadryl 1.0 mg/kg IM/IV** up to a maximum of 50 mg.

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ANAPHYLAXIS - PEDIATRIC
(Continued)

SEVERE Red, itchy skin; hives; and severe swelling of face, lips, tongue, or pharynx; possible severe SOB; BP well below normal limits according to patient age.

EMT:

- 1) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed.
- 2) If present, scrape stinger out. Stabilize involved extremity and apply ice.
- 3) Apply venous tourniquet on involved extremity above injection or sting site, if present.
- 4) **EPI Pen** if available.
- 5) **Epinephrine 1:1,000, 0.01 mg/kg IM** up to a maximum dose of 0.5 mg. Repeat q 5 min., as needed.
- 6) Transport ASAP

AEMT:

As above

- 7) If airway is patent with BVM and adjunct continue.
- 8) **Isotonic Solution 20 ml/kg fluid challenge IV/IO.** Repeat once to achieve minimum BP for age and clinical improvement capillary refill < 2 sec., stronger pulses, warmer extremities, improving LOC). Contact receiving physician to consider additional fluid administration.

PARAMEDIC:

As above

- 9) Cardiac monitor
- 10) **Epinephrine * 1:10,000, 0.01 mg/kg IV/IO *** slowly up to a maximum dose of 0.5 mg. Repeat q 5 min., as needed.
- 11) **Benadryl 1.0 mg/kg IV/IO** up to a maximum of 50 mg.
- 12) Consider starting Inhalation treatment (or via ETT, if intubated) for bronchospasms with **Albuterol (2.5mg) & Atrovent (0.5mg) at 6LPM**; may repeat treatment of Albuterol q5 minutes up to a maximum of three times and Atrovent (max of 1 additional time)
- 13) If needed intubate with ET Tube or King airway attach end tidal CO2 monitoring (confirm oxygenation & ventilation) if not Intubate Patient if patient respirations are less than 8 per minute.

* This drug may be given via the endotracheal tube if an IV cannot be established. The ET dose is double the IV dose.

(End)

BRADYCARDIA - PEDIATRIC

IF PATIENT IS ASYMPTOMATIC:

EMT:

- 1) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed
- 2) Consider calling for ALS
- 3) Transport ASAP

AEMT/PARAMEDIC:

As above

- 4) **Isotonic Solution IV/IO** TKO rate.

IF PATIENT LOOKS SICK *:

EMT:

- 1) Bag-valve-mask ventilate with 100% O₂,
- 2) Consider CPR for HR < 80 INFANT and for HR < 60 CHILD.
- 3) Transport ASAP.

AEMT:

As above

- 4) **Isotonic Solution IV/IO**
- 5) **Consider bolus** 20ml/kg in small increments if lungs sounds are clear.

PARAMEDIC:

As above

- 6) Cardiac monitor.
- 7) Place ET Tube or King airway, attach end tidal CO₂ monitoring (confirm oxygenation & ventilation) if not Intubate Patient if patient respirations are less than 8 per minute.
- 8) **Epinephrine 1:10,000, 0.01 mg/kg IV/IO** or 0.1 mg/kg ET ** q 3-5 min.
- 9) **Atropine 0.02 mg/kg IV/IO *****, repeated once, if needed.
- 10) Complete Heart Block **Transcutaneous Pacing**

* May include significant respiratory difficulty or one or more of the following signs of shock:

- a) altered LOC
- b) capillary refill > 2 sec.
- c) rapid pulse
- d) diminished distal pulses
- e) cool extremities
- f) hypotension

** In order to avoid high volumes, the 1:1,000 solution should be used for this dose by diluting it to a total of 3 ml with NS.

*** This drug may be given via the endotracheal tube if IV access cannot be establish. The ET dose is double the IV dose.

(End)

FEVER - PEDIATRIC

Oral or rectal temperature greater than 38 C (100 F).

EMT/AEMT:

- 1) Remove clothing from patient.
- 2) If no problem other than fever identifiable, no therapy required at scene. If child appears toxic, do not delay transport.
- 3) For fever associated with seizure:
 - A) High Flow O2 and assist as needed 8-15 LPM by mask or blowby.
 - B) If fever > 103 F, initiate cooling by removing clothing.
 - C) If patient in status epilepticus, treat according to Pediatric Seizures protocol

AEMT:

As above

- 1) **Isotonic Solution** IV TKO consider 20 ml/kg bolus if signs of dehydration

PARAMEDIC:

As above

- 2) Cardiac monitor
- 3) Contact on-line medical control as necessary for consultation.

(End)

HYPOGLYCEMIA - PEDIATRIC

As suggested by lethargy or coma in a known diabetic.

EMT:

- 1) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed
- 2) **Check Blood glucose level** If capillary blood glucose < 60,
- 3) Oral glucose if able to swallow
- 4) Consider call for ALS
- 5) Transport ASAP
- 6) Perform secondary assessment; look for signs of trauma

AEMT:

As above

- 7) **Isotonic Solution IV/IO.**
- 8) If blood glucose < 60,
 - A) **1.0 ml/kg D25W IV/IO push.** If patient < 1 year, dilute 1:1 with NS.
- 9) **Glucagon 1.0 mg IM,** blood glucose < 60 and unable to establish IV/IO

PARAMEDIC:

As above

- 10) Cardiac monitor
- 11) If no response to above measures, follow Pediatric Coma protocol

(End)

**PULSELESS ELECTRICAL ACTIVITY (PEA)/ASYSTOLE * -
(Non Shockable) PEDIATRIC**

EMT:

- 1) Check Respirations and pulse
- 2) Perform 5 cycles of CPR if heart rate less than 60 BPM with poor perfusion
- 3) Airway adjunct and supplemental **O2 15 LPM** via BVM
- 4) Attach AED (after two minutes of CPR) if available
- 5) Perform 5 cycles of CPR
- 6) Two no shocks advised
- 7) Continue CPR Package and transport
- 8) Call for ALS

AEMT:

As above *

- 9) **Isotonic Solution IV/IO 20 ml/kg** fluid challenge as rapidly as possible. Repeat once to achieve minimum BP for age and clinical improvement (capillary refill < 2 sec., stronger pulses, warmer extremities, improving LOC). Contact receiving physician to consider additional fluid administration.

PARAMEDIC:

As above

- 10) Cardiac Monitor
- 11) **Epinephrine 1:10,000, 0.01-0.03 mg/kg IV/IO**. Repeat q 3-5 min.
- 12) Consider cardiac pacing
- 13) If King airway in place / attach end tidal CO2 monitoring (confirm oxygenation & ventilation) if not Intubate Patient if patient respirations are less than 8 per minute.

* Consider treatable causes, such as hypoxemia, acidosis, hypovolemia, tension pneumothorax, cardiac tamponade, etc.

(End)

RESPIRATORY ARREST - PEDIATRIC

EMT:

- 1) Establish and secure airway. *
- 2) Bag-valve-mask ventilate with 100% O₂
- 3) Assist ventilation, as needed, using adequate volume/pressure to make chest rise and breath sounds audible,
- 4) Monitor pulse oximetry, if available. Titrate O₂ administration and ventilation to maintain O₂ stats at 90% or greater.

AEMT

As above

- 5) Isotonic Solution IV/IO TKO.
- 6) Chemstrip. If capillary blood glucose < 60,
A) **D25W IV/IO 1.0 ml/kg** push. If patient < 1 year, dilute 1:1 with NS.
- 7) **Narcan 0.1 mg/kg** IV/IO/IM ** to a maximum dose of 2.0 mg.

PARAMEDIC:

As above

- 8) If airway is patent with BVM and adjunct continue if unable to maintain airway:
- 9) If intubating patient attach end tidal CO₂ monitoring. **INTUBATION SHOULD BE CONSIDERED EARLY ON IF PATIENT'S AIRWAY IS COMPROMISED IN ANY WAY OR IF GCS IS < 8**

* If airway positioning alone returns spontaneous respirations, oxygenate at high flow rate, and assist ventilations, as necessary. If spontaneous respirations do not return, ventilate with bag-valve-mask, and perform endotracheal intubation in a controlled manner. If airway is obstructed, follow foreign body protocol.

** This drug may be given via the endotracheal tube if IV access cannot be established. The ET dose is double the IV dose.

(End)

RESPIRATORY DISTRESS - PEDIATRIC

MILD DISTRESS: Alert; pink; comfortable; able to speak easily.

EMT/AEMT/PARAMEDIC:

- 1) Observe respirations; auscultate lungs.
- 2) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed.
- 3) Transport ASAP

MODERATE DISTRESS: Tachypneic; slight accessory muscle use; minimal retractions.

EMT:

- 1) Observe respirations; auscultate lungs.
- 2) Allow patient to assume position of comfort, with parent if necessary.
- 3) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed
- 4) Assist patient with Doctor prescribed **inhaler**.
- 5) Consider call for ALS
- 6) Transport ASAP

AEMT/PARAMEDIC:

As above

- 7) Cardiac monitor.
- 8) IV Isotonic Solution
- 9) 10-20 ml/kg as needed
- 10) Administer **0.5% Albuterol 2.5 mg**
- 11) **PARAMEDIC Atrovent 0.5mg** via nebulized treatment.
- 12) Consider CPAP if >8yo

(Continued)

RESPIRATORY DISTRESS – PEDIATRIC
(Continued)

SEVERE DISTRESS: Tachypneic; accessory muscle use; retractions; difficulty speaking; cyanosis.

EMT:

- 1) Follow steps 1-6 for moderate distress.

AEMT/PARAMEDIC:

As above

- 2) Cardiac monitor.
- 3) **Isotonic Solution** IV/IO at TKO rate.
- 4) Administer **0.5% Albuterol 2.5 mg** via nebulized treatment Q 20 minutes (max 5mg)
- 5) **PARAMEDIC Atrovent 0.5 mg** via nebulized treatment.
- 6) Contact Medical Control for **IM epinephrine, 1:1,000 (0.01 mg/kg (max 0.3 mg dosage))** for severe forms of reactive airway disease; may be repeated q 10 minutes.
- 7) If intubating patient attach end tidal CO2 monitoring. INTUBATION SHOULD BE CONSIDERED EARLY ON IF PATIENT'S AIRWAY IS COMPROMISED IN ANY WAY OR IF GCS IS < 8
- 8) Strongly encouraged to consult ED for use of CPAP on child under 14 years old in cases of severe forms of airway disease.

(END)

RESPIRATORY DISTRESS WITH STRIDOR - PEDIATRIC

Stridor is a harsh inspiratory sound indicating upper airway obstruction.

MILD OR MODERATE DISTRESS: Tachypneic; slight accessory muscle use; minimal retractions; pink.

EMT/AEMT/PARAMEDIC:

- 1) Observe respirations; auscultate lungs.
- 2) Allow patient to assume position of maximal comfort, with parent if necessary.
- 3) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed
- 4) Consider calling for ALS
- 5) Transport ASAP

SEVERE DISTRESS: Tachypneic; accessory muscle; retractions.

EMT/AEMT:

- 6) Follow steps 1-5 for moderate distress.

PARAMEDIC:

As Above

- 7) Cardiac Monitor
- 8) Consider **Epinephrine 1:1,000 2.5ml nebulized (2.5 mg SVN).**
- 9) If intubating patient attach end tidal CO2 monitoring. INTUBATION SHOULD BE CONSIDERED EARLY ON IF PATIENT'S AIRWAY IS COMPROMISED IN ANY WAY OR IF GCS IS < 8

(End)

SEIZURES - PEDIATRIC

EMT:

- 4) Protect patient and patient's airway from harm.
- 5) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed. After Seizure stops
- 6) Call for ALS
- 7) Transport ASAP

AEMT:

As above

- 5) Isotonic Solution IV/IO TKO.
- 6) Blood glucose < 60,
 - A) **D25W 2-4 ml/kg IV/IO**. If patient < 1 year, dilute 1:1 with NS. AEMT only
 - B) or if unable to establish IV administer **Glucagon 0.025 mg/kg IM** AEMT only

PARAMEDIC:

As above

- 7) Cardiac Monitor
- 8) If seizure lasts greater than 5 minutes and IV is not established, administer **Midazolam 0.2mg/kg IM max 5mg, 0.2mg/kg IN max 10mg or Lorazepam 0.05 mg/kg max 4 mg**, IM, or rectally, then attempt IV.
- 9) If seizure lasts greater than 5 minutes and IV is in place, administer **Midazolam 0.1mg/kg IV (max dosage = 5.0 mg)** or **Lorazepam 0.05 mg/kg (max dosage = 4.0mg)** may repeat once in 5 minutes
- 10) If King airway in place / attach end tidal CO2 monitoring (confirm oxygenation & ventilation) if not Intubate Patient if patient respirations are less than 8 per minute.

(End)

SUDDEN INFANT DEATH SYNDROME (SIDS)

Sudden death, without apparent cause, during sleep. Affects infants usually less than six (6) months of age. May be difficult to differentiate from suspected child abuse.

EMT:

- 1) CPR, unless obvious signs of death.
- 2) Support parents, avoiding questions or comments suggesting blame.
- 3) Observe and carefully note:
 - A) Location and position of child.
 - B) Objects immediately surrounding child.
 - C) Behavior of all adults present.
 - D) Explanations provided.
 - E) Vomitus in mouth or foreign body, if present.
- 4) Report all observations to Medical Control or County Coroner or Law Enforcement.

AEMT/PARAMEDIC:

- As above
- 5) Cardiac monitor.
 - 6) Treat arrhythmias appropriately.

(End)

TACHYARRYTHMIAS WITH PULSE - PEDIATRIC

PATIENT WITHOUT SIGNS OF SHOCK: *

EMT:

- 1) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed
- 2) Consider calling ALS
- 3) Transport ASAP.

AEMT/PARAMEDIC:

As above

- 4) Cardiac Monitor
- 5) **Isotonic Solution IV/IO** at TKO

PATIENT WITH SIGNS OF SHOCK:

EMT:

- 1) **O2 4 – 6 Liters Nasal Cannula** Maintain pulse ox between 94% and 96% switch to NRB 10-15 Liters if needed. Be prepared to assist ventilations if needed
- 2) Consider Calling ALS
- 3) Transport ASAP

AEMT:

As above

- 4) **Isotonic Solution IV/IO 20 ml/kg** fluid challenge as rapidly as possible. Repeat once to achieve minimum BP for age and clinical improvement (capillary refill < 2 sec., stronger pulses, warmer extremities, improving LOC). If signs of shock persist, contact receiving physician to consider additional fluid administration.

PARAMEDIC:

As above

- 5) Cardiac Monitor
- 6) **Adenocard, 0.1 mg/kg**, bolus,
- 7) **Adenocard 0.2 mg/kg** bolus,
- 8) Wide Complex **Amiodarone 5mg/kg IV max. 150mg** infuse over 30 min.
- 9) **Etomidate 0.1mg/kg IV**
- 10) **Synchronized cardioversion at 0.5-1.0 joules/kg.**

* Signs of shock may include:

- a) altered LOC
- b) capillary refill > 2 sec.
- c) rapid pulse
- d) diminished distal pulses
- e) cool extremities
- f) hypotension

(End)

TRAUMA/SHOCK - PEDIATRIC

EMT:

- 1) Take spinal precautions.
- 2) Establish and secure a patent airway while maintaining in-line axial support.
- 3) High flow O2. Assist ventilations, as needed.
- 4) Consider calling ALS
- 5) Transport ASAP

AEMT:

As above

6) **Isotonic Solution IV/IO**

A) **20 ml/kg fluid challenge** as rapidly as possible if signs of shock present *.

B) Repeat X 1 to achieve minimum BP for age and clinical improvement (capillary refill < 2 sec., stronger pulses, warmer extremities, improving LOC). If signs of shock persist, contact receiving physician to consider additional fluid administration.

PARAMEDIC:

As above

- 7) Cardiac Monitor
- 8) Consider administration of **Versed 0.15 – 0.30 mg/kg**
- 9) Consider analgesia for musculoskeletal trauma or burns; **Morphine (0.1 mg/kg) IV/IO/IM.**
Titrate to effect
- 10) Consider **Zofran 0.1mg/kg IV/IM/PO** for Nausea &/or Vomiting
- 11) If signs of **head injury present ****:
- 12) Elevate head 15 degrees if patient has no signs of shock, observing spinal precautions.
- 13) If intubating patient attach end tidal CO2 monitoring. **INTUBATION SHOULD BE CONSIDERED EARLY ON IF PATIENT'S AIRWAY IS COMPROMISED IN ANY WAY OR IF GCS IS < 8 or signs of airway burns (maintain c-spine control during any intubation attempt)**
- 14) Consider **Dopamine 2-10mcg/kg/min IV** or **Epinephrine 2-10mcg/min IV** if hypotension is not trauma related

* Shock is defined by a combination of:

- a) altered LOC
- b) capillary refill > 2 sec.
- c) rapid pulse
- d) diminished distal pulses
- e) cool extremities
- f) hypotension

** Signs of increased intracranial pressure include dilated pupils, focal neurological signs, decreased LOC, posturing, and/or GCS level < 8.

(End)

**VENTRICULAR FIBRILATION/ PULSELESS VENTRICULAR TACHYCARDIA
(Shockable) - PEDIATRIC**

EMT:

- 1) Check Respirations and pulse
- 2) Perform 5 cycles of CPR
- 3) Airway adjunct and supplemental **O2 15 LPM** via BVM
- 4) Attach AED (after two minutes of CPR) if available
- 5) Perform 5 cycles of CPR
- 6) Two no shocks advised
- 7) Continue CPR Package and transport
- 8) Call for ALS

AEMT:

As above

- 9) **Isotonic Solution IV/IO 20 ml/kg** fluid challenge as rapidly as possible. Repeat once to achieve minimum BP for age and clinical improvement (capillary refill < 2 sec., stronger pulses, warmer extremities, improving LOC). Contact receiving physician to consider additional fluid administration.
- 10) If airway is patent with BVM and adjunct continue.

PARAMEDIC:

- 11) ET Tube or place King airway / attach end tidal CO2 monitoring (confirm oxygenation & ventilation) if not Intubate Patient if patient respirations are less than 8 per minute.
- 12) **Defib 2 joules/kg.**
- 13) Perform 5 cycles of CPR
- 14) **Defib 4 joules/kg.**
- 15) Perform 5 cycles of CPR and:
 - A) **Epinephrine 1:10,000, 0.01-0.03 mg/kg IV/IO.** Repeat q 3-5 min., as needed,
- 16) **Defib 4 joules/kg.**
- 17) Perform 5 cycles of CPR and:
 - A) **Amiodarone 5 mg/kg IV/IO (max dose 300 mg)**
- 18) **Defib 4 joules/kg.**
- 19) Continue alternating between 5 cycles of CPR with med admin and Defib.

* In order to avoid high volumes, the 1: 1,000 solution should be used for this dose by diluting it to a total of 3 ml with NS.

** This drug may be given via the endotracheal tube if IV access cannot be established. The ET dose is double the IV dose.

(End)