Checked against NREMT sources. Published Oct 11, 2026.

Primary Assessment

Share of the exam	Tables	Tested facts
39 to 43%	**4**	**7**

PEARL
Two thinking errors are named: tunnel vision, becoming focused on one aspect of the patient's condition and missing something important; and trusting normal vital signs, which do not exclude severe injury because the body compensates for a time, especially in children and young adults.

PEARL
A patient who appears unresponsive may still hear you. Avoid remarks that could raise anxiety.

Adjunct selection and sizing

Adjunct	Patient	Sizing
Oropharyngeal airway	Apneic, unresponsive, no gag reflex, being ventilated	Corner of the mouth to the earlobe or angle of the jaw
Nasopharyngeal airway	Unconscious, uninjured, breathing adequately, or will not tolerate an oral airway; avoided with severe head or facial trauma where basilar skull fracture is suspected	Tip of the nose to the earlobe
Rigid tonsil-tip (Yankauer) suction	Fluid and thick secretions in the mouth, for no more than 15 seconds at a time	Like an oral airway: corner of the mouth to the earlobe

The ventilation numbers	
Item	**Value**
Adequate breathing	A regular rate around 16 with equal bilateral chest rise
Inadequate breathing	For example rate 28, shallow, diminished breath sounds: that patient needs ASSISTED VENTILATION, not more oxygen
Adult ventilation	One breath every 5 to 6 seconds (10 to 12 per minute), about 600 mL, just enough for visible chest rise, delivered slowly and gently
Effectiveness check	Visible equal chest rise and fall, and a heart rate returning to normal
Nonrebreathing mask	10 to 15 L/min
Nasal cannula	Up to 6 L/min

The resuscitation numbers	
Item	**Value**
Adult CPR	100 to 120 per minute, 2 to 2.4 inches deep, 30:2
Two-rescuer paediatric ratio	15:2
Infant compressions	Two fingers just below the nipple line, about 1.5 inches
Compression fraction	The share of resuscitation time spent compressing: aim for at least 60 per cent
Lone rescuer, child	About 2 minutes (five cycles) of CPR before leaving to call and get an AED
AED near an implanted device	Pad at least 1 inch away, then proceed normally

Normal ranges		
Patient	**Heart rate**	**Respiratory rate**
Infant	90 to 180 (below 80 abnormal)	
Child	70 to 120	20 to 30 per minute
Adult	60 to 100	12 to 20 per minute

PEARL

Tell a child what you are about to do immediately before doing it, in simple literal language: it prevents a preschooler developing frightening fantasies about what is coming. Let a toddler keep a comfort object, assess an infant in a caregiver's arms, offer a structured choice rather than an open question, keep the parent present, appear confident and calm, and be honest.

TESTED

- ☑ Each of these makes a patient high priority ON ITS OWN: a poor general impression; altered level of consciousness still present at the end of assessment; uncontrolled bleeding; pale skin or other signs of poor perfusion; severe pain anywhere in the body; and difficulty with airway, breathing or circulation. Being very old or very young can make a patient critical even when they look relatively stable.
- ☑ Short-term memory is the first cognitive function to go, and the baseline comes from family or caregivers: ask what the patient's NORMAL mental status is rather than assuming the current state is new.
- ☑ Where a patient has both an airway full of fluid and other problems, suction the airway FIRST.
- ☑ Two signs commonly misread as improvement are the opposite: a FALLING respiratory rate in a patient who has been working hard, and the DISAPPEARANCE of accessory muscle use in a tiring patient, are ominous signs of impending respiratory arrest from fatigue.
- ☑ Severe external bleeding and an airway problem together: control the life-threatening bleeding FIRST. And capillary refill is not a reliable perfusion indicator in older adults, because of skin changes and reduced circulation.
- ☑ A significant mechanism of injury means a FULL rapid exam of the entire body regardless of how well the patient looks: ejection from a vehicle, a gunshot wound, a fall of more than 20 feet in an adult or more than about 10 feet (or 2 to 3 times height) in a child, and significant vehicle deformity or intrusion. An unresponsive patient also gets a full-body exam, because they cannot tell you what is wrong.
- ☑ Narrow pulse pressure is a shock finding. Systolic minus diastolic, and narrower than 25 mm Hg is the number to remember, because the narrowing can appear while the systolic reading still looks acceptable.

Patient Treatment & Transport

Share of the exam	Tables	Tested facts
20 to 24%	**11**	**17**

PEARL
A pulsating abdominal mass with pain is an expanding or leaking aortic aneurysm: do not palpate it, and do not elevate the legs, because increased venous return may worsen the leak. Melena is black tarry digested blood; hematochezia is grossly bloody stool.

PEARL
Crush release is a reperfusion event: sudden freeing of a crushed limb can trigger acute hypovolaemia, electrolyte abnormalities and a lethal arrhythmia in a patient who looked stable and alert while trapped. The calm trapped patient is exactly the one to worry about.

Delivery complications

Finding	Meaning and action
Crowning	Delivery is imminent: prepare to deliver at the scene, since labour cannot be slowed or stopped
Green-tinged amniotic fluid	Meconium, fetal stool: signals possible fetal distress and a risk of meconium aspiration
Nuchal cord	Clamp the cord in two places, cut between them ONCE, then unwrap the loops from the neck
Breech presentation	Support the body without pulling; the mother's pushing efforts deliver the head
Limb presentation	Cannot be delivered vaginally in the field: supportive care and immediate transport for surgical delivery

PEARL
A sick child who becomes quieter and stops resisting the examination is not settling, they are deteriorating. Age-inappropriate behaviour, poor muscle tone or poor eye contact means inadequate cerebral perfusion and needs urgent attention. And a child with sickle cell anaemia carries a particularly high risk of ischaemic stroke.

PEARL

The aged brain shrinks, stretching the bridging veins between its surface and its covering, so they tear with minor trauma; add an anticoagulant and the bleeding does not stop. That is why the older patient on warfarin gets a subdural haematoma from a mechanism that would bruise anyone else.

SIDS facts

Item	Fact
Definition	Death of an infant or young child that remains unexplained even after a complete autopsy
Toll	About 3,500 infants die of SIDS annually (CDC)
Risk factors	Mother younger than 20, maternal smoking during pregnancy, low birth weight
Prevention	Back sleeping on a firm mattress, crib free of bumpers, blankets and toys; same room as an adult but never the same bed

Hypoglycaemia versus hyperglycaemia

Feature	Hypoglycaemia	Hyperglycaemia
Onset	Minutes	Gradual, hours to days
Skin	Pale, moist, clammy	Warm and dry
Pulse	Rapid and weak	
Breathing		Deep rapid Kussmaul respirations with a fruity breath odour
Correction	Reversed within minutes by glucose	A complex metabolic condition taking many hours to correct even in hospital

Routes and why they work

Route	Why
Sublingual	The richly vascular tissue under the tongue absorbs the drug within minutes and avoids breakdown by stomach acids
Intranasal (atomiser)	The nasal mucosa is highly vascular, giving fast absorption without a needle
Auto-injector	Delivers a preset accurate intramuscular dose quickly and safely, with no drawing up from a vial

Blast injury mechanisms

Type	Mechanism	Signature
Primary	The pressure wave itself	Ruptured eardrums and lungs
Secondary	Flying debris: shrapnel, glass, splinters	Multiple penetrating wounds
Tertiary	The body hurled against a stationary object	Impact injuries, ground shock

Which splint for which injury

Injury	Answer
Clavicle, scapula, AC separation	Sling and swathe, holding the arm against the chest wall
Femoral SHAFT fracture	Traction splint
Proximal femur (hip) in a geriatric patient	NO traction splint: backboard or scoop with pillows or rolled blankets supporting the limb as found
Lower leg, ankle, foot	NO traction splint: padded rigid, air or pillow splint including the foot up to the knee

Seizure recognition

Type	Picture
Absence (petit mal)	A brief staring lapse of consciousness, seconds long, no motor change, full rapid recovery
Simple partial (focal)	No change in consciousness; numbness, weakness, dizziness or twitching of a limb
Complex partial	Altered mental status with lip smacking, blinking, repetitive behaviour, from the temporal lobe
Typical febrile	Generalised, under 15 minutes, short or absent postictal phase

Dislocation patterns

Injury	Story and posture
Patella	Teenagers and athletes; knee moderately flexed, patella displaced laterally; splint as found
Knee, posterior	The most common knee dislocation, from extreme hyperextension; high risk of popliteal artery injury
Hip, posterior	Knee strikes the dashboard; hip flexed, knee drawn toward the chest, thigh rotated inward over the opposite leg

Burn depth

Depth	Appearance
Superficial (first degree)	Red top layer only, no blisters
Partial thickness (second degree)	Blisters with moist, mottled, white-to-red skin, intensely painful
Full thickness (third degree)	Dry, leathery, white, brown or charred, painless in the deepest area

Croup, epiglottitis, bronchiolitis		
Disease	**Cause**	**Picture**
Croup (laryngotracheobronchitis)	Viral, below the vocal cords	Gradual onset after a cold, barking seal-like cough, stridor, low-grade fever; ages 6 months to 3 years
Epiglottitis	Bacterial; incidence dropped sharply since the childhood vaccine	Sudden onset in a well child: high fever, severe sore throat, tripod position, drooling
Bronchiolitis	Usually respiratory syncytial virus	Wheezing in the first 2 years of life, more common in boys, peaking winter and early spring

Heat emergencies		
Condition	**Mechanism**	**Skin and care**
Heat cramps	Electrolyte shift from sweating	Alert, normal temperature; rest, cool environment, water
Heat exhaustion	Hypovolaemia from water and electrolyte loss in sweat	Cold, clammy, pale skin, rapid weak pulse, temperature normal or mildly raised
Heat stroke	Cooling has failed; core temperature climbing	Cold-water immersion once core temperature reaches 104 degrees Fahrenheit or mental status is altered

PEARL

Anterograde points forward in time: the patient cannot lay down new memories after the blow, which is why the same question comes again and again. Retrograde points backwards: the minutes before the event are the ones that are gone.

TESTED

- ☑ Anaphylaxis: epinephrine 0.3 mg intramuscularly in the lateral thigh, held firmly for about 10 seconds, given THROUGH clothing rather than delaying to expose the leg. The effects can wear off before the reaction resolves, so a second dose and continued monitoring may be needed.
- ☑ Hobbling or hog-tying a patient prone with hands and feet secured behind the back is the restraint practice to REFUSE. Extreme agitation with reduced pain sensitivity, persistent struggling and an elevated temperature needs ALS help, since some of these patients require chemical restraint for safe transport.

- [x] Blood from the nose or ears after a head injury may mean skull fracture: do NOT try to stop the flow. Cover loosely with sterile gauze, because pressure could force the leaking blood to collect inside the head and raise pressure on the brain. Ordinary nontraumatic nosebleeds arise from the nasal septum and are controlled by pinching the fleshy cartilaginous part of the nostrils, never the bony bridge.
- [x] Ventilating a child: watch the rise and fall of the chest wall and use only enough force to make the chest rise slightly, at the child's own rate. Squeezing the bag hard and completely delivers an excessive tidal volume. Activated charcoal in a child is dosed at about 1 gram per kilogram, so a 20 kg child gets about 20 grams.
- [x] AMI pain builds gradually, often with nausea, indigestion, weakness and sweating, and is described as pressure. Dissection pain arrives at full force from one minute to the next and is described as stabbing. The sudden maximal onset is the discriminator.
- [x] A valid DNR order generally requires a clear statement of the patient's medical problem and the signature of the patient or legal guardian along with the signature of a physician or other licensed health care provider.
- [x] With no ALS responding and local protocol agreeing, begin transport of a cardiac arrest patient once the patient regains a pulse, six to nine shocks have been delivered, or the AED gives a no shock advised message on three consecutive analyses separated by CPR.
- [x] Painless heavy vaginal bleeding as early labour begins is placenta previa, the placenta covering the cervix. Significant PAIN with bleeding points instead to abruptio placentae. A missed period with sudden severe one-sided lower abdominal pain is an ectopic pregnancy until proven otherwise. An eclamptic seizure gets the left side position, airway care, oxygen, suction for vomiting and rapid transport with an ALS intercept.
- [x] The last known well time is the last time the patient was WITNESSED to be free of symptoms, not the time symptoms were discovered. Found symptomatic at 6 am but last seen normal at 10 pm: the answer is 10 pm. And even when the treatment window seems passed, transport promptly and report the exact time, because eligibility is decided at the hospital, never in the field.
- [x] Even a vague suggestion of suicide is never dismissed. Ask directly: are you considering suicide? The question does not plant the idea.
- [x] The most feared pulmonary blast injury is ARTERIAL AIR EMBOLISM: disrupted alveoli let air into the circulation, and even small bubbles reaching a coronary or cerebral artery cause myocardial injury or neurologic change. Pulmonary blast injury shows chest tightness or pain, tachypnoea, coughing up blood, and subcutaneous emphysema crackling under the chest skin.
- [x] A febrile seizure lasting around 20 minutes or with a FOCAL onset is outside the benign pattern and may mean meningitis or another serious cause: treat and transport with urgency. An altered patient who vomits goes in the recovery position with suctioning as needed, unless spinal injury is suspected.
- [x] Assess neurovascular function distal to any musculoskeletal injury every 5 to 10 minutes until the patient reaches the hospital, because fragments or a deformed joint can compress vessels and nerves at any point. And a traction splint is contraindicated for a partial amputation with separated bone ends: traction risks completing the separation.
- [x] Asthma is RARE in children younger than 1 year, so a wheezing infant that young should make you think bronchiolitis instead. RSV produces copious secretions: suction as needed. A prolonged unrelieved asthma attack is status asthmaticus, a true emergency needing oxygen and rapid transport, and the anxious struggling patient who suddenly seems calmer is exhausting toward respiratory arrest, not recovering.

- [x] Every athlete who sustains a concussion is evaluated by a QUALIFIED healthcare provider before returning to play, using tools such as computerised testing against a baseline. EMTs are not qualified to perform return-to-play clearance, and neither the athlete's own report of feeling better nor a coach's opinion substitutes.
- [x] A ruptured aorta kills almost immediately from the sheer internal blood loss. Aneurysms are nearly impossible to diagnose in the field, so significant hypertension plus the right pain pattern is treated as one: transport without delay, drive smoothly avoiding bumps, do not palpate again, and remember the pulsating mass is a RARE sign whose absence rules nothing out.
- [x] Before assisting with any of the patient's own medication, confirm it has been prescribed specifically for that patient. A spouse's identical inhaler or a neighbour's nitroglycerin does not qualify. There is no manufacturing-date rule, no prior-use restriction, and no family-consent requirement that outranks an alert, competent patient's own wishes.

Scene Size-Up & Safety

Share of the exam	Tables	Tested facts
15 to 19%	**2**	**2**

The three zones		
Zone	**What it is**	**EMS role**
Hot	The contaminated area	None
Warm	The transition area: access control points and the decontamination corridor	None routinely: carrying large bags in is impractical, which is why care there is limited
Cold	Safe, no special protective clothing	Triage, treatment and transport of decontaminated patients, from a designated area

Mass casualty facts	
Item	**Rule**
Declaring	An EMT can declare a mass casualty incident; only an elected official can declare a disaster
Duration	An MCI generally lasts no longer than a few hours; a disaster can run days to weeks
Self-sufficiency	Plan for at least 72 hours, supported by mutual aid agreements
DMAT	Federal Disaster Medical Assistance Teams arrive with their own equipment
Freelancing	An individual unit or responder acting outside the coordinated command structure
Casualty collection area	Where teams triage, treat and prioritise

TESTED

- [x] The size-up asks three questions: does the scene pose a threat to you, your patient or others; how many patients are there; and do we have the resources to respond. The number of patients directly drives whether you request additional resources and whether you begin the incident command system.
- [x] Battlefield-style care is an exception carved out for an unsecured area under threat of gunfire. Carrying it into an ordinary call is the wrong answer: outside that narrow setting the standard of care is unchanged.

Operations

Share of the exam	Tables	Tested facts
10 to 14%	**2**	**4**

Triage and command facts	
Item	**Rule**
START-style sorting	Ability to walk, respiratory status, pulse status, neurologic status
Respiratory thresholds	Fewer than 15 or more than 45 breaths per minute
Apneic child	Five rescue breaths and recheck; if still not breathing, tag expectant
Reverse triage	Apneic and pulseless victims who would normally be expectant are treated first
Divisions versus groups	Divisions share a geographic area; groups share a function
Staging officer	Tracks arrivals and releases units
Transportation officer	Distributes patients among hospitals so none is overwhelmed, tracked by the tag's unique number

Radio modes at a glance	
Mode	**What it allows**
Simplex	Push to talk, release to listen: either direction, but only one at a time
Duplex	Simultaneous two-way transmission and reception on a channel
Multiplex	More than one type of information carried at once on a single frequency

PEARL

Sort the stress answers by timing. The alarm stage and an acute stress reaction happen at the event. A cumulative stress reaction builds over time. PTSD surfaces later, with flashbacks and startle reactions.

TESTED

- [x] Negligence has four elements: duty, breach of duty, causation and damages. Abandonment is transferring care to someone not trained or competent to continue it, or failing to complete the transfer of care at the hospital.
- [x] Restraints are used ONLY to protect the patient or others from harm, with only the reasonable force necessary to control the patient. Restraining a person without authority in a non-emergency situation invites charges of assault, battery or false imprisonment.
- [x] Good faith is the hinge on a mandated report. Report the suspicion: most reporting statutes protect the reporter from defamation liability even when the report turns out to be unfounded.
- [x] The ICS sits inside NIMS. Any option that makes NIMS a component of the ICS, or says one replaced the other, is wrong.

Secondary Assessment

Share of the exam	Tables	Tested facts
5 to 9%	**0**	**0**

No tables or tested facts in this domain yet; the guide covers it in prose. The share above is still the real exam's.

Sources this sheet is checked against

- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), patient assessment
- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), mental status assessment
- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), airway management, with Anatomy & Physiology for the Prehospital Provider (Jones & Bartlett)
- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), breathing assessment and ventilation
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- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), resuscitation and assessment of trauma patients
- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), paediatric assessment
- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), patient assessment and shock
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- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), trauma and environmental emergencies
- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), obstetrics and gynaecology, with National Model EMS Clinical Guidelines (NASEMSO, Version 3.0, March 2022)
- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), behavioural emergencies
- Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), soft-tissue injuries, face and neck injuries, and bleeding

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Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), head and spine injuries and trauma overview

Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), soft-tissue injuries, shock and environmental emergencies

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Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), infection control

Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), workforce safety and wellness, and infectious diseases

Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), infectious diseases

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Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), medical, legal and ethical issues

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Emergency Care and Transportation of the Sick and Injured (AAOS / Jones & Bartlett), secondary assessment

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