EMT OB/Pediatrics Study Guide

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This study guide covers Obstetrics (OB) and Pediatrics for EMTs. It aligns with the NREMT EMT certification exam (updated format effective April 2025), National EMS Scope of Practice Model 2019 (with Change Notices), National EMS Education Standards, and AHA BLS Guidelines 2025 (current as of 2026). OB/GYN and Pediatrics content is integrated across exam domains, particularly Medical emergencies and Patient Treatment and Transport (~10–15% of exam content combined). EMT Scope Limitations: Assist with uncomplicated vaginal deliveries; provide basic neonatal resuscitation (BLS level); perform pediatric assessment and basic support. No advanced medications (e.g., no magnesium sulfate, oxytocin, or advanced airway interventions). Prioritize rapid transport to appropriate facility; use pediatric-specific equipment and length-based resuscitation tape (e.g., Broselow) when available. AHA 2025 Neonatal BLS Updates (EMT-Relevant): Deferred cord clamping ≥60 seconds if the newborn is vigorous and does not require resuscitation; initial ventilation rate 30–60 breaths/min; emphasize skin-to-skin contact, warming, drying, and stimulation; focus on the Newborn Chain of Care.

Section 1: Obstetrics (OB) for EMTs

Key Physiology: After ~20 weeks gestation, supine position can cause vena cava compression → transport in left lateral recumbent position whenever possible.

Rapid OB Assessment: Ask about last menstrual period (LMP), gravidity/para (G/P), estimated due date, prenatal care, contractions, bleeding, membrane rupture, and crowning/urge to push.

Common OB Emergencies & EMT Management:

Emergency	Signs/Symptoms	EMT Management	Key Notes
Imminent Delivery	Crowning, strong urge to push, contractions <2–3 min apart	Prepare OB kit; support controlled delivery; check for nuchal cord; clamp/cut cord; dry/stimulate newborn; fundal massage after placenta.	Call for ALS backup; rapid transport; never delay for delivery if transport is faster.
Postpartum Hemorrhage	Heavy vaginal bleeding after delivery; boggy uterus	Perform fundal massage (firm circular pressure on fundus); position patient to control bleeding; keep warm; high-flow O&sub2; if hypotensive; rapid transport.	Primary cause is uterine atony; control bleeding with massage and positioning.
Breech Presentation	Buttocks or feet presenting first	Support body gently; do NOT pull; urgent transport for hospital delivery/management.	Field delivery rare and high-risk; avoid traction on legs.
Prolapsed Cord	Umbilical cord visible/palpable before baby	Place mother in knee-chest or Trendelenburg position; cover cord with moist sterile dressing; manually elevate presenting part off cord; rapid transport.	Do NOT push cord back in; keep cord warm and moist.

Emergency	Signs/Symptoms	EMT Management	Key Notes
Eclampsia	Severely pregnant patient (often with HTN, headache, visual changes)	Protect airway, place in left lateral position; high-flow O&sub2;; suction if needed; rapid transport.	Avoid anti-seizure medications; treat as medical emergency.

Normal Vaginal Delivery Steps (NREMT Skill Emphasis):

Take/verbalize BSI/PPE; prepare OB kit and position mother.

Support perineum to control head delivery (reduce tearing).

Check for nuchal cord (slip over head if loose; clamp/cut if tight).

Deliver anterior then posterior shoulder (gentle downward traction on head for anterior).

Support baby as it delivers; clamp cord twice (2 clamps ~4–6 inches from baby), cut between.

Dry, stimulate, warm newborn; assess breathing and heart rate.

Deliver placenta; perform fundal massage to promote uterine contraction.

Reassess mother and baby; transport promptly.

Section 2: Neonatal Care (BLS Level – EMT Scope)

Initial Neonatal Assessment & Care: Warm, dry, and stimulate (rub back, flick soles of feet). Assess: Term gestation? Good tone? Breathing or crying?If Not Breathing or HR <100 bpm: Provide positive pressure ventilation (PPV) with BVM at 30–60 breaths/min; ensure visible chest rise. If HR <60 bpm after 30 seconds of effective PPV: Begin chest compressions (3:1 ratio with ventilations; two-thumb encircling technique preferred).

APGAR Scoring: Performed at 1 and 5 minutes (Appearance, Pulse, Grimace, Activity, Respiration); used for documentation, not to guide resuscitation.

2025 AHA BLS Highlights for EMTs: Prioritize ventilation over compressions initially; deferred cord clamping if vigorous; skin-to-skin contact promotes bonding and temperature regulation.

Section 3: Pediatrics Overview for EMTs

Approximate Pediatric Vital Signs (Normal Ranges):

Age Group	Heart Rate (bpm)	Respiratory Rate (breaths/min)	Systolic BP (mmHg)
Newborn	120–160	40–60	>60
Infant (0–1 yr)	100–160	30–40	>70
Child (1–8 yr)	80–140	20–30	>80

Pediatric Assessment Triangle (PAT) – High-Yield for NREMT:

Appearance: Tone, interactivity, consolability, look/gaze, speech/cry (TICLS).

Work of Breathing: Abnormal sounds, positioning, retractions, flaring, grunting.

Circulation to Skin: Pallor, mottling, cyanosis, cap refill (>2 sec abnormal).

Common Pediatric Emergencies & EMT Management:

Emergency	Signs/Symptoms	EMT Management	Key Notes
Respiratory Distress	Retractions, nasal flaring, grunting,	High-flow O&sub2; (titrate to SpO&sub2; 94–98%); position of comfort; assist with	Common causes: Asthma, croup, bronchiolitis,

Emergency	Signs/Symptoms	EMT Management	Key Notes
	hypoxia, accessory muscle use	prescribed inhaler (albuterol) if available; rapid transport.	foreign body.
Hypoglycemia	Altered mental status, seizures, poor feeding, irritability	Check blood glucose if able; give oral glucose (if conscious and able to swallow); transport.	Common in diabetics or prolonged fasting.
Seizures	Convulsions, staring, post-ictal state	Protect airway (recovery position if breathing); high-flow O&sub2;; suction if needed; do NOT place anything in mouth; transport.	No oral intake during active seizure; febrile seizures common in young children.
Fever/Dehydration	Hot skin, tachycardia, sunken fontanelles, poor urine output	O&sub2; if hypoxic; comfort measures; rapid transport (especially infants).	Assist with acetaminophen if prescribed and patient can swallow.
Suspected Abuse/Neglect	Inconsistent history, patterned bruises, burns, fractures	Treat life threats first; document findings objectively; report to authorities; transport.	Mandatory reporting for suspected child abuse.

Pediatric BLS Key Points:

Compression-to-ventilation ratio: 30:2 (single rescuer); 15:2 (two rescuers).

Rate: 100–120 compressions/min. Depth: Approximately 1/3 anterior-posterior chest diameter.

Use pediatric pads/AED mode for children <8 years or <55 lbs.

Tips for NREMT Success:

Focus on primary assessment priority (ABCs), scene safety, family-centered care, and knowing when to request ALS intercept (e.g., complicated delivery, neonatal distress). Practice pediatric sizing of equipment and length-based tape usage. Good luck on your EMT certification exam—stay calm, assess systematically, and prioritize safety!