

26-1 EMS Protocol Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. For needle thoracostomy in suspected pneumothorax with absent or diminished lung sounds, the statement that both SBP < 90 mmHg and SpO2 < 94% must be present is true or false?**
 - A. True**
 - B. False**
 - C. Only SBP < 90 mmHg is required**
 - D. Only SpO2 < 94% is required**

- 2. In pediatric pulseless arrest, the initial epinephrine dose is 0.01 mg/kg.**
 - A. 0.1 mg/kg**
 - B. 0.01 mg/kg**
 - C. 0.001 mg/kg**
 - D. 1 mg/kg**

- 3. What is the initial dose of Epinephrine for pediatric pulseless arrest?**
 - A. 0.1 mg/kg**
 - B. 0.001 mg/kg**
 - C. 0.01 mg/kg**
 - D. 1 mg/kg**

- 4. Which SRMC facility is included in their specialty services?**
 - A. Labor and Delivery**
 - B. Neonatal Intensive Care Unit**
 - C. Burn Center**
 - D. Transplant Services**

- 5. What energy is used to cardiovert Wide Regular rhythms (MVT)?**
 - A. 50 J**
 - B. 100 J**
 - C. 200 J**
 - D. 300 J**

- 6. What is the correct concentration and dose for epinephrine for an adult asthmatic in severe distress?**
- A. 1:1000 0.01 mg/kg (MAX 0.5 mg)**
 - B. 1:10000 0.01 mg/kg**
 - C. 1:1000 0.1 mg/kg**
 - D. 1:1000 0.01 mg/kg (MAX 0.2 mg)**
- 7. What is the maximum total fentanyl dose listed for severe pain management?**
- A. 100 mcg**
 - B. 150 mcg**
 - C. 200 mcg**
 - D. 250 mcg**
- 8. Direct oral anticoagulants (DOACs) include which medication?**
- A. Warfarin**
 - B. Heparin**
 - C. Apixaban**
 - D. Clopidogrel**
- 9. What is the maximum IM dose of Epinephrine (1:1000) allowed for pediatric patients?**
- A. 0.3 mg**
 - B. 1.0 mg**
 - C. 0.15 mg**
 - D. 0.5 mg**
- 10. Which route is used for amiodarone dosing in pediatric cardiac arrest?**
- A. IV/IO**
 - B. PO**
 - C. IM**
 - D. Subcutaneous**

Answers

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1. B
2. B
3. C
4. A
5. B
6. A
7. C
8. C
9. A
10. A

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Explanations

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1. For needle thoracostomy in suspected pneumothorax with absent or diminished lung sounds, the statement that both SBP < 90 mmHg and SpO2 < 94% must be present is true or false?

A. True

B. False

C. Only SBP < 90 mmHg is required

D. Only SpO2 < 94% is required

The key idea is that needle decompression is guided by clinical signs of tension pneumothorax and patient instability, not by meeting two exact numerical thresholds. A patient with absent or diminished lung sounds and suspected tension pneumothorax should be decompressed promptly if there is signs of instability, such as low blood pressure or low oxygen saturation. It's not necessary for both SBP to be below 90 and SpO2 to be below 94% at the same time; either finding can indicate significant physiologic compromise that warrants immediate treatment. Delaying decompression to wait for both criteria could worsen outcomes, since the pressure buildup behind a tension pneumothorax can rapidly impair ventilation and circulation.

2. In pediatric pulseless arrest, the initial epinephrine dose is 0.01 mg/kg.

A. 0.1 mg/kg

B. 0.01 mg/kg

C. 0.001 mg/kg

D. 1 mg/kg

In pediatric pulseless arrest, the goal of epinephrine is to improve blood flow to the heart and brain during CPR by tightening the vessels and raising coronary perfusion pressure. The standard starting dose is 0.01 mg/kg of a 1:10,000 solution given IV or IO, with repeats every 3-5 minutes until there's return of a pulse or ROSC. This small, weight-based dose provides enough vasoconstriction to boost perfusion without causing excessive hypertension or arrhythmias in children. Doses that are too high could provoke dangerous hypertension and tachyarrhythmias, while doses that are too low may not improve perfusion adequately. If epinephrine must be given via the endotracheal route, the dose is typically increased to account for poorer absorption, but IV/IO administration remains the standard during CPR.

3. What is the initial dose of Epinephrine for pediatric pulseless arrest?

- A. 0.1 mg/kg
- B. 0.001 mg/kg
- C. 0.01 mg/kg**
- D. 1 mg/kg

When a child has a pulseless collapse, epinephrine is given to boost blood flow to the heart and brain during CPR by narrowing small vessels and increasing diastolic pressure. The standard initial dose is 0.01 mg/kg IV/IO, repeated every 3-5 minutes; this corresponds to 0.1 mL/kg of a 1:10,000 epinephrine solution (since 1 mL of 1:10,000 contains 0.1 mg). Dosing higher, like 0.1 mg/kg or 1 mg/kg, is far too much for pediatrics and can cause harm, while 0.001 mg/kg would be too small to achieve the desired perfusion.

4. Which SRMC facility is included in their specialty services?

- A. Labor and Delivery**
- B. Neonatal Intensive Care Unit
- C. Burn Center
- D. Transplant Services

Specialty services are departments that require focused, high-level care with specialized staff and resources beyond everyday inpatient care. Labor and Delivery fits this idea because childbirth and obstetric emergencies need a dedicated team of obstetricians, anesthesia providers, nurses trained in labor and fetal monitoring, and ready access to surgical suites and neonatal support. That level of specialized, around-the-clock capability is why Labor and Delivery is listed as a specialty service at SRMC. The other units—the Neonatal Intensive Care Unit, Burn Center, and Transplant Services—are all highly specialized as well, but they are typically categorized as specific patient-care areas or programs, and the question reflects SRMC's particular listing of specialty services, where Labor and Delivery is highlighted.

5. What energy is used to cardiovert Wide Regular rhythms (MVT)?

- A. 50 J
- B. 100 J**
- C. 200 J
- D. 300 J

When a wide, regular tachycardia is actually monomorphic VT with a pulse, you treat it with synchronized cardioversion. The starting energy for this approach is 100 J on a modern biphasic defibrillator. Using a synchronized shock targets the VT rhythm at the moment of the R wave to reduce the risk of inducing another arrhythmia, while still delivering enough energy to terminate the tachycardia. If the first attempt doesn't work, you increase the energy—typically to 200 J, then 300 J, and possibly 360 J depending on the device and protocol. The lower energy options are not appropriate as the initial shock, while higher energies would be used only if needed after the first attempt.

6. What is the correct concentration and dose for epinephrine for an adult asthmatic in severe distress?

- A. 1:1000 0.01 mg/kg (MAX 0.5 mg)**
- B. 1:10000 0.01 mg/kg**
- C. 1:1000 0.1 mg/kg**
- D. 1:1000 0.01 mg/kg (MAX 0.2 mg)**

Dosing epinephrine for an adult in severe asthma distress uses a 1:1000 intramuscular injection given in a weight-based amount of 0.01 mg per kilogram, with a per-dose maximum of 0.5 mg. This approach provides effective bronchodilation through beta-2 effects while keeping cardiovascular risks in check. The 1:1000 concentration is appropriate for IM use in acute bronchospasm, whereas 1:10000 is an IV dilution not used for IM injections in this scenario. A dose of 0.1 mg/kg would be far too high for a single dose, risking severe tachycardia and hypertension. A maximum of 0.2 mg per dose is also too low to reliably treat severe distress in many adults.

7. What is the maximum total fentanyl dose listed for severe pain management?

- A. 100 mcg**
- B. 150 mcg**
- C. 200 mcg**
- D. 250 mcg**

Fentanyl has a high potency, so the guidelines place a ceiling on how much a patient can receive in total to provide pain relief while minimizing the risk of serious side effects like respiratory depression. The maximum total dose listed for severe pain management is 200 micrograms. Doses are typically given in smaller increments and titrated up until adequate analgesia is achieved or the 200 mcg total is reached. The other amounts (lower or higher than this cap) either would not reflect the stated maximum or would exceed safe limits in this protocol.

8. Direct oral anticoagulants (DOACs) include which medication?

- A. Warfarin**
- B. Heparin**
- C. Apixaban**
- D. Clopidogrel**

Direct oral anticoagulants are oral medicines that directly block specific coagulation factors to prevent clot formation. Apixaban fits this category because it directly inhibits factor Xa, lowering thrombin generation and clotting. Warfarin works differently as a vitamin K antagonist, which reduces several clotting factors but is not a DOAC. Heparin is typically given by injection and also isn't a DOAC, and clopidogrel is an antiplatelet, not an anticoagulant. Other DOACs include rivaroxaban, edoxaban, and dabigatran.

9. What is the maximum IM dose of Epinephrine (1:1000) allowed for pediatric patients?

- A. 0.3 mg**
- B. 1.0 mg**
- C. 0.15 mg**
- D. 0.5 mg**

Pediatric IM dosing for epinephrine (1:1000) is weight-based, given as 0.01 mg/kg per dose, with a maximum of 0.3 mg per injection. That cap protects smaller patients from overdose while still delivering an effective dose. Because the solution is 1 mg/mL, 0.3 mg equates to 0.3 mL of solution. So the highest safe per-dose amount a child should receive is 0.3 mg. Doses above this would exceed the per-injection limit, while smaller children may receive less depending on weight.

10. Which route is used for amiodarone dosing in pediatric cardiac arrest?

- A. IV/IO**
- B. PO**
- C. IM**
- D. Subcutaneous**

In pediatric cardiac arrest, delivering the drug quickly and reliably is crucial. Amiodarone needs to reach the heart fast to help treat shock-refractory ventricular tachycardia or ventricular fibrillation, so the IV or IO route is used. Intravenous or intraosseous access provides rapid, predictable absorption and onset, which is essential during resuscitation. Oral administration wouldn't work in this emergency because absorption is slow and unpredictable, and the patient isn't maintaining adequate oral intake. Intramuscular or subcutaneous routes are not suitable here due to unreliable absorption and delayed effect in children. If IV access isn't immediately available, intraosseous access offers a fast alternative to keep the drug moving toward the heart without delaying treatment.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://261emsprotocol.examzify.com>

We wish you the very best on your exam journey. You've got this!

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