

26-1 EMS PROTOCOL PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. What does the FAST acronym stand for in stroke assessment?**
 - A. Face drooping, Arm weakness, Speech difficulties, Time to call for help.
 - B. Arm weakness, Face drooping, Speech difficulties, Time to call for help.
 - C. Face drooping, Time to call for help, Arm weakness, Speech difficulties.
 - D. Speech difficulties, Face drooping, Arm weakness, Time to call for help.

- 2. What are essential steps in managing suspected hypothermia?**
 - A. Gentle handling, remove wet clothing, gradual rewarming, monitor for arrhythmias, provide warm IV fluids if protocol allows
 - B. Rapid rewarming with direct heat to the chest
 - C. Keep patient cold to prevent overheating
 - D. Withhold IV fluids entirely

- 3. Pediatric patients in SSV are ages what maximum?**
 - A. 15 or older
 - B. 12 or younger
 - C. 14 or less
 - D. 18 or younger

- 4. Which of the following best describes the initial step in EMS primary assessment?**
 - A. Check blood glucose
 - B. Obtain a full patient history
 - C. Ensure scene safety and perform a rapid assessment of airway, breathing, and circulation to identify life threats
 - D. Apply oxygen therapy

- 5. In EMS documentation, which statement correctly distinguishes subjective and objective data?**
 - A. Subjective data are patient-reported symptoms; objective data are measurable findings from examination and vitals.
 - B. Subjective data are lab results; objective data are patient feelings.
 - C. Subjective data are clinician impressions; objective data are rumors.
 - D. Subjective data are physical exam findings; objective data are symptoms.

- 6. When a patient refuses EMS care, which elements should the documentation include?**
- A. Capacity and refusal must be documented
 - B. No documentation is required
 - C. Capacity, informed refusal, discussion of risks, alternatives offered, witnesses, and signature
 - D. Signature is optional
- 7. In the field, which action helps prevent hypothermia during initial neonatal care?**
- A. Provide warmth to the newborn
 - B. Immediate defibrillation
 - C. Delay warming until transport
 - D. Avoid skin-to-skin contact
- 8. What is a common alternative route when IV access is not readily obtainable for medications?**
- A. Oral administration
 - B. Endotracheal administration
 - C. Intramuscular (IM) access
 - D. Intravenous (IV) access
- 9. Which routes are used for midazolam dosing in pediatric seizure management?**
- A. PO and IV
 - B. IM/IN or IV/IO
 - C. IM only
 - D. IV only
- 10. Narcan dose is specified for which patient population?**
- A. Pediatric overdose
 - B. Adult overdose
 - C. Both pediatric and adult
 - D. None

Answers

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

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Explanations

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1. What does the FAST acronym stand for in stroke assessment?

- A. Face drooping, Arm weakness, Speech difficulties, Time to call for help.
- B. Arm weakness, Face drooping, Speech difficulties, Time to call for help.
- C. Face drooping, Time to call for help, Arm weakness, Speech difficulties.
- D. Speech difficulties, Face drooping, Arm weakness, Time to call for help.

FAST is a quick-screening approach to identify potential stroke and act fast. Face drooping signals weakness on one side of the face; have the person smile to spot asymmetry. Arm weakness is checked by asking them to stretch both arms straight ahead to see if one drifts downward. Speech difficulties include slurred speech or trouble speaking clearly. Time to call for help emphasizes calling emergency services immediately so the person can get urgent evaluation and treatment. The four elements together—Face drooping, Arm weakness, Speech difficulties, Time to call for help—provide a simple, rapid way to recognize a possible stroke and prompt fast action.

2. What are essential steps in managing suspected hypothermia?

- A. Gentle handling, remove wet clothing, gradual rewarming, monitor for arrhythmias, provide warm IV fluids if protocol allows
- B. Rapid rewarming with direct heat to the chest
- C. Keep patient cold to prevent overheating
- D. Withhold IV fluids entirely

In suspected hypothermia, the priority is to prevent further heat loss and rewarm the patient carefully while protecting the heart from stresses that can trigger dangerous rhythms. Gentle handling is essential because rough movement can provoke arrhythmias in a cold, fragile heart. Removing wet clothing stops ongoing heat loss, and then rewarming should be gradual: use passive measures such as dry clothes, blankets, and a warm environment to conserve what's left of the patient's heat, followed by active external warming (like warming blankets or heat packs placed on the trunk) if available. Avoid rapid or direct heating to the chest or elsewhere with high heat, which can cause burns or push heat into the core too quickly and create complications like afterdrop. Continuous monitoring of vital signs and especially heart rhythm is crucial since hypothermia alters conduction and can lead to dangerous rhythms. If protocol allows, warmed IV fluids can aid internal rewarming and hydration; avoid cold IV fluids. In severe cases, follow hypothermia-specific resuscitation guidelines.

3. Pediatric patients in SSV are ages what maximum?

- A. 15 or older
- B. 12 or younger
- C. 14 or less
- D. 18 or younger

The concept being tested is how this system defines who counts as pediatric for specific protocols. In this SSV framework, a pediatric patient is someone fourteen years old or younger. This cutoff is used so that treatment, equipment sizing, and dosing align with pediatric guidelines, which differ from adult protocols. Once a patient is older than fourteen, adult protocols apply. So the maximum age for pediatric in SSV is fourteen years or younger.

4. Which of the following best describes the initial step in EMS primary assessment?

- A. Check blood glucose
- B. Obtain a full patient history
- C. Ensure scene safety and perform a rapid assessment of airway, breathing, and circulation to identify life threats**
- D. Apply oxygen therapy

The initial step in the EMS primary assessment is to make the scene safe and then quickly check airway, breathing, and circulation to identify any life threats. This approach focuses first on preventing harm to the responders and patient, then on finding conditions that could cause rapid deterioration. By assessing airway patency, breathing effectiveness, and circulation (including bleeding and signs of shock), you determine what needs immediate intervention—opening or protecting the airway, providing ventilation or oxygen, and controlling severe bleeding or improving circulation. These actions take priority over gathering a full history or waiting on other treatments. Checking blood glucose, obtaining a full patient history, or simply applying oxygen without first confirming life threats does not address the most urgent needs. The primary survey guides you to the critical, life-saving steps before moving on to the secondary assessment and more detailed history.

5. In EMS documentation, which statement correctly distinguishes subjective and objective data?

- A. Subjective data are patient-reported symptoms; objective data are measurable findings from examination and vitals.**
- B. Subjective data are lab results; objective data are patient feelings.
- C. Subjective data are clinician impressions; objective data are rumors.
- D. Subjective data are physical exam findings; objective data are symptoms.

Subjective data are patient-reported symptoms and experiences, while objective data are measurable findings you can observe or obtain through examination and vital signs. In practice, if a patient says they have chest pain, dizziness, or nausea, that information is subjective. If you record a blood pressure, pulse, respirations, temperature, and observable signs like pallor, sweating, or abnormal lung sounds, those are objective. This distinction matters in EMS documentation because it separates what the patient feels from what you can verify through measurement and observation. Lab results fall under objective data, since they are test-derived measurements, and clinician impressions or rumors do not fit the defined data categories. Symptoms are subjective, whereas physical exam findings and vitals are objective.

6. When a patient refuses EMS care, which elements should the documentation include?

- A. Capacity and refusal must be documented
- B. No documentation is required
- C. Capacity, informed refusal, discussion of risks, alternatives offered, witnesses, and signature**
- D. Signature is optional

When a patient refuses EMS care, you must document that they had decision-making capacity and that the refusal was informed. The best documentation includes: evidence of capacity (the patient seemed able to understand and weigh consequences), a record of informed refusal (the patient was told what could happen if they declined), discussion of risks (what might worsen or occur without treatment), alternatives offered (other options or resources discussed), witnesses who observed the conversation, and the patient's signature (or an acceptable mark) with date and time. This combination shows the patient made a voluntary, educated decision rather than a coerced or uninformed one, and it provides legal and clinical protection while guiding any follow-up care. If capacity isn't present or cannot be assessed, a valid refusal isn't possible, and care or further assessment would be pursued instead.

7. In the field, which action helps prevent hypothermia during initial neonatal care?

- A. Provide warmth to the newborn**
- B. Immediate defibrillation
- C. Delay warming until transport
- D. Avoid skin-to-skin contact

Providing warmth to the newborn right after birth is essential to prevent hypothermia in the field. Newborns lose heat quickly and have limited ability to regulate temperature, so rapid warming helps reduce metabolic stress, protect glucose levels, and support breathing. In practice, dry the baby, wrap them snugly in a dry blanket, and place a warm hat on the head, aiming for skin-to-skin contact with a caregiver if possible or using a radiant warmer to maintain warmth. Waiting to warm until transport lets heat escape and worsens cooling. Immediate defibrillation isn't part of routine neonatal stabilization, and avoiding skin-to-skin contact increases heat loss, making hypothermia more likely.

8. What is a common alternative route when IV access is not readily obtainable for medications?

- A. Oral administration
- B. Endotracheal administration
- C. Intramuscular (IM) access**
- D. Intravenous (IV) access

When IV access isn't readily obtainable, intramuscular administration is a common practical alternative because it delivers medication systemically without needing a drawn-out IV line. It's relatively quick to perform in the field and doesn't require specialized IV equipment, making it a reliable option when time is critical and IV access is difficult or failing. The absorption from muscle tissue is generally predictable enough for many emergency meds, so you can still get a therapeutic effect promptly. Endotracheal administration exists historically as a route when IV access is not available, but it is less reliable and dosing can vary widely between patients, so it's not the preferred default in most scenarios. Oral administration is often impractical in emergencies because the patient is frequently unconscious or unable to swallow, and absorption through the GI tract can be unpredictable. IV remains the standard route when accessible, but intramuscular injection serves as a practical backup when IV access is not readily obtainable.

9. Which routes are used for midazolam dosing in pediatric seizure management?

- A. PO and IV
- B. IM/IN or IV/IO**
- C. IM only
- D. IV only

Midazolam dosing in pediatric seizure management relies on multiple routes because rapid, flexible administration is crucial when a child is seizing. Intranasal and intramuscular routes allow quick drug delivery without needing IV access, which is often not readily available in an emergency. If IV access is already in place or can be obtained quickly, intravenous dosing provides fast onset as well. In situations where IV access is not feasible, intraosseous administration offers an IV-like route to deliver the medication promptly. This combination of IM/IN or IV/IO reflects the real-world options clinicians use to secure rapid control of seizures. Oral administration isn't suitable in an acute seizure setting due to slow, unpredictable absorption and the risk of aspiration, so it isn't used for rescue dosing.

10. Narcan dose is specified for which patient population?

- A. Pediatric overdose**
- B. Adult overdose
- C. Both pediatric and adult
- D. None

Dosing Narcan is driven by patient size, so pediatric dosing is specified with weight-based calculations. In children, the amount given is tied to body weight (for example, 0.1 mg/kg per dose, IV or IM), and the dose is often repeated every few minutes until reversal is achieved. This explicit, per kilogram guidance is provided because small changes in dose can have a big impact in kids, making precise dosing essential. Adults, while still dosed to reverse opioid effects, are typically managed with broader, less strictly weight-based protocols, so the dosing is not as explicitly defined per kilogram in many EMS guidelines. That focus on weight-based, clearly specified dosing for children is why the Narcan dose is specified for pediatric overdose.

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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