PEDIATRIC EDUCATION FOR PREHOSPITAL PROFESSIONALS (PEPP) PRACTICE EXAM (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.

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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!

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Questions

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1. In the field management of a near-drowning pediatric patient, after ensuring airway and providing rescue breaths, what is the next priority?

A. Administer antibiotics.

B. Perform chest compressions.

C. Monitor for hypoxia and transport promptly.

D. Obtain blood tests on scene.

2. What are the alternate IO insertion sites?

A. Distal femur or distal tibia

B. Proximal humerus

C. Proximal tibia

D. Lateral malleolus

3. What is the most common cause of seizures in children?

A. Fever

B. Head injury

C. Electrolyte imbalance

D. Infection

4. What is the recommended approach to pediatric poisoning in the field?

A. Induce vomiting.

B. Provide only fluids and wait for EMS.

C. Decontaminate with emesis without guidance.

D. Ensure airway and breathing, call poison control, identify substance, avoid inducing vomiting, and decontaminate as needed.

5. What are the four types of shock?

A. Hypovolemic, Cardiogenic, Distributive, Obstructive

B. Hypovolemic, Cardiogenic, Anaphylactic, Septic

C. Hypoxic, Cardiogenic, Distributive, Obstructive

D. Hypovolemic, Neurogenic, Distributive, Obstructive

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6. Which scales are commonly used to assess pediatric neurologic status in the field?

A. AVPU scale or pediatric Glasgow Coma Scale.

B. APGAR score.

C. MMSE.

D. RASS.

7. What do the letters in TICLS mean and which part of the PAT are they used in?

A. Tone; Interactiveness; Consolability; Look/Gaze; Speech/Cry; Appearance of PAT

B. Temperature; Irritability; Color; Lethargy; Speech; Circulation to Skin

C. Tone; Interactivity; Consolability; Look; Cry; Circulation to Skin

D. Tone; Interactivity; Consolability; Look; Cry; Appearance of PAT

8. What is the minimum systolic blood pressure for infants older than one month?

A. Greater than 65 systolic

B. Greater than 60 systolic

C. Greater than 70 systolic

D. Greater than 75 systolic

9. What is the maximum first-dose adenosine amount for pediatric SVT?

A. 6 mg

B. 12 mg

C. 4 mg

D. 9 mg

10. Hydration decisions during heat stroke should consider the child's consciousness and ability to drink.

A. False

B. True

C. Only after cooling finished

D. Only via IV regardless of consciousness

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Answers

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

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Explanations

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1. In the field management of a near-drowning pediatric patient, after ensuring airway and providing rescue breaths, what is the next priority?

A. Administer antibiotics.

B. Perform chest compressions.

C. Monitor for hypoxia and transport promptly.

D. Obtain blood tests on scene.

The main idea is to keep the child well-oxygenated and get them to definitive care quickly. After securing the airway and giving rescue breaths, the greatest risk in near-drowning is ongoing hypoxia, which can lead to brain injury and other complications if not promptly addressed. So the next priority is to monitor oxygenation and ventilation status, provide adequate oxygen, and arrange prompt transport to a pediatric-capable facility for definitive care. Antibiotics aren't routinely given at this stage and won't fix the immediate problem. Chest compressions are only needed if the child develops pulselessness or signs of poor perfusion, not as the immediate next step. Blood tests on scene don't change the urgent management and should not delay transport.

2. What are the alternate IO insertion sites?

A. Distal femur or distal tibia

B. Proximal humerus

C. Proximal tibia

D. Lateral malleolus

When a child needs rapid vascular access and IV lines are hard to obtain, intraosseous access is the fastest alternative. The most common IO site in kids is the proximal tibia, but if that isn't feasible or has failed, there are reliable alternate entry points. The distal femur and the distal tibia provide good medullary access in pediatric patients, making them the standard alternate sites. The distal femur is especially useful in younger children because the marrow space is accessible despite small limb size, and the distal tibia offers another accessible window when tibial plateau access isn't possible. The lateral malleolus isn't used for IO in standard practice, and while the proximal humerus can be used in some protocols, the question focuses on the commonly accepted alternate sites, which are the distal femur and distal tibia.

3. What is the most common cause of seizures in children?

A. Fever

B. Head injury

C. Electrolyte imbalance

D. Infection

Fever is the most common trigger for seizures in children, especially during viral illnesses in the age range roughly 6 months to 5 years. These febrile seizures occur when a fever is present and the immature nervous system is more prone to convulsing; they're typically brief and generalized and do not imply epilepsy. That makes fever the leading cause among pediatric seizures. Other causes like head injury, electrolyte disturbances, or infections can provoke seizures, but they are far less common overall compared with febrile seizures in this population. In practice, a child with a fever who has a seizure is most often experiencing a febrile seizure, and management centers on protecting the airway and circulation, controlling the fever, and evaluating for serious conditions only if red flags appear.

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4. What is the recommended approach to pediatric poisoning in the field?

A. Induce vomiting.

B. Provide only fluids and wait for EMS.

C. Decontaminate with emesis without guidance.

D. Ensure airway and breathing, call poison control, identify substance, avoid inducing vomiting, and decontaminate as needed.

In pediatric poisoning in the field, the priority is to protect the child's life by securing the airway and breathing first, then gather information and get expert guidance, identify what was involved, avoid triggering vomiting, and perform decontamination as needed. Ensuring a clear airway and adequate breathing is the foundation because hypoxia or respiratory collapse can occur quickly in children, so ventilatory support and oxygen are addressed before anything else. Calling poison control brings real-time, poison-specific guidance and can direct whether antidotes or particular decontamination steps are indicated, helping to avoid inappropriate or harmful actions. Identifying the substance—by asking caregivers and checking containers or labels—lets responders tailor the management and communicate details to the receiving hospital. Vomiting is avoided because it increases the risk of aspiration and can cause additional injury, especially with caustic or toxin-containing substances, and it is not reliably beneficial. Decontamination in the field focuses on safe, practical measures: removing contaminated clothing and rinsing the skin or eyes with water if splashed, and performing decontamination only when it is safe and indicated, under guidance from poison control or medical direction. This approach emphasizes protecting the child's airway, obtaining expert direction, and applying targeted, safe decontamination rather than reflexively attempting remedies like induced vomiting.

5. What are the four types of shock?

A. Hypovolemic, Cardiogenic, Distributive, Obstructive

B. Hypovolemic, Cardiogenic, Anaphylactic, Septic

C. Hypoxic, Cardiogenic, Distributive, Obstructive

D. Hypovolemic, Neurogenic, Distributive, Obstructive

Shock is categorized by the underlying problem with circulating blood. The four broad types are hypovolemic, cardiogenic, distributive, and obstructive. Hypovolemic shock arises from loss of intravascular volume (bleeding, dehydration). Cardiogenic shock results from pump failure of the heart (myocardial infarction, significant arrhythmias). Distributive shock involves widespread vasodilation and maldistribution of blood flow (seen in sepsis, anaphylaxis, and neurogenic causes). Obstructive shock is due to a physical barrier to blood flow (cardiac tamponade, tension pneumothorax, massive pulmonary embolism). Other options mix conditions that aren't separate categories of shock or represent just causes within distributive shock (like anaphylaxis or septic shock) or label a non-shock issue (hypoxic). The four primary categories above best capture the major mechanisms of shock.

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6. Which scales are commonly used to assess pediatric neurologic status in the field?

A. AVPU scale or pediatric Glasgow Coma Scale.

B. APGAR score.

C. MMSE.

D. RASS.

When you need a quick, reliable read on a child's neurologic status in the field, use simple, rapid tools designed for prehospital care. The AVPU scale gives an immediate snapshot of consciousness by categorizing the child as Alert, responding to Voice, responding to Pain, or Unresponsive. If you need more detail or will be tracking changes over time, the pediatric Glasgow Coma Scale provides an age-appropriate, structured assessment of eye opening, verbal response, and motor response, producing a score you can compare to baseline or documentation. Other options aren't typically used for field pediatric neuro assessment. The APGAR score is for newborns right after birth, not for ongoing neurologic evaluation in the field. The MMSE is a cognitive screen designed for adults, not children. The Richmond Agitation-Sedation Scale is a ICU-focused tool for sedation levels, not a general prehospital neurologic assessment.

7. What do the letters in TICLS mean and which part of the PAT are they used in?

A. Tone; Interactiveness; Consolability; Look/Gaze; Speech/Cry; Appearance of PAT

B. Temperature; Irritability; Color; Lethargy; Speech; Circulation to Skin

C. Tone; Interactivity; Consolability; Look; Cry; Circulation to Skin

D. Tone; Interactivity; Consolability; Look; Cry; Appearance of PAT

TICLS is a quick checklist for assessing how a child is presenting, focusing on appearance. Tone describes muscle tone and energy; Interactivity looks at how the child responds to people and surroundings; Consolability gauges how easily the child can be soothed; Look/Gaze assesses eye contact and visual tracking; Speech/Cry notes the quality of the cry or speech. Taken together, these elements form the Appearance portion of the Pediatric Assessment Triangle, not the breathing or circulation parts. The other PAT components are Work of Breathing and Circulation to Skin, so TICLS specifically evaluates appearance. Therefore, the correct choice lists Tone; Interactivity; Consolability; Look/Gaze; Speech/Cry and identifies them as part of the Appearance of the PAT.

8. What is the minimum systolic blood pressure for infants older than one month?

A. Greater than 65 systolic

B. Greater than 60 systolic

C. Greater than 70 systolic

D. Greater than 75 systolic

Pediatric blood pressure is age-dependent, so the minimum systolic pressure that indicates adequate perfusion increases as children grow. For infants older than one month, a systolic blood pressure of about 65 mmHg or higher is considered the lower limit of normal. Values below this suggest hypotension and possible shock in this age group, guiding you to escalate care. The other numbers correspond to different ages: 60 mmHg is typically used as the lower threshold for neonates, while higher thresholds like 70 mmHg or 75 mmHg are associated with older children rather than this infant subgroup.

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9. What is the maximum first-dose adenosine amount for pediatric SVT?

A. 6 mg

B. 12 mg

C. 4 mg

D. 9 mg

Adenosine for pediatric SVT is given as a rapid IV bolus with a dose of 0.1 mg/kg, but the first dose is capped at 6 mg. This limit keeps the initial dose within a safe range while still providing a high likelihood of terminating the reentrant SVT, since adenosine acts extremely quickly and its effects are short-lived. If the first dose doesn't terminate the tachycardia, a second dose can be given at 0.2 mg/kg (up to 12 mg). Administer with a rapid flush, monitor the ECG continuously, and be prepared for brief pauses in rhythm or other transient side effects. If the patient is unstable, proceed with cardioversion rather than waiting for dosing. Thus, the maximum first-dose amount is 6 mg.

10. Hydration decisions during heat stroke should consider the child's consciousness and ability to drink.

A. False

B. True

C. Only after cooling finished

D. Only via IV regardless of consciousness

Hydration decisions during heat stroke must be tailored to the child's consciousness and ability to drink. If a child is alert and able to swallow safely, you can start oral rehydration with appropriate fluids while rapid cooling continues, because this supports fluid balance without delaying treatment and avoids unnecessary IV access. If the child is drowsy, confused, vomiting, or otherwise unable to protect the airway, giving fluids by mouth is unsafe, and IV fluids are indicated to rapidly restore perfusion and prevent further deterioration. Cooling is the priority, but hydration can and should be addressed in parallel, choosing the method that matches the child's mental status and swallowing ability. In short, the right approach to hydration depends on whether the child can drink safely, with IV reserved for those who cannot.

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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:

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

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