SNHD PARAMEDIC PROTOCOLS 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.

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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. If the RACE score is 5 or higher and BgL is 60-400, what should you do?

A. Tele to receiving facility

B. Vascular Access

C. Cardiac Monitor/12 Lead

D. Rapid transport to NIR capable facility

2. If seizures persist after magnesium sulfate in a pregnant patient, what is the maximum initial dose of midazolam?

A. 5 mg

B. 2 mg

C. 10 mg

D. 1 mg

3. What is the fluid bolus for an AMS pediatric patient with BgL >60 mg/dl?

A. Oxygen therapy

B. Dextrose 5% IV

C. NS or LR 20 mL/kg IV/IO; may repeat up to 60 mL/kg

D. NS or LR 20 mL/kg IV/IO; may repeat up to 60 mL/kg; if BgL >250, then 10 mL/kg bolus

4. Which of the following is NOT an approved vagal maneuver?

A. Valsalva maneuver

B. Head-down tilt with deep inspiration

C. Activation of the diving reflex by facial immersion in ice water (unless ischemic heart disease is present)

D. Administration of adenosine

5. Before performing vagal maneuvers, what must be in place?

A. Oxygen saturation above 95 percent

B. The patient must be hemodynamically stable

C. The patient must be attached to a cardiac monitor and have vascular access

D. Defibrillation equipment must be checked and ready

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6. Which of the following is an NIR capable center in Las Vegas?

A. Mount Charleston General

B. Paradise Valley Medical Center

C. Sunrise

D. Riverside Valley Hospital

7. What is the maximum dose of diphenhydramine?

A. 25 mg

B. 50 mg

C. 75 mg

D. 100 mg

8. Stridor management references which protocol?

A. Chest pain ACS protocol

B. Seizure protocol

C. Pulmonary edema protocol

D. Allergic reaction protocol

9. Postpartum symptoms of preeclampsia/eclampsia may present after delivery for up to how long?

A. 48 hours

B. 2 weeks

C. 3 months

D. Up to 6 weeks

10. What should be given for mild to moderate pain?

A. Ibuprofen

B. Morphine

C. Ketamine

D. Acetaminophen 1 g IV/IO

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Answers

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

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Explanations

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1. If the RACE score is 5 or higher and BgL is 60-400, what should you do?

A. Tele to receiving facility

B. Vascular Access

C. Cardiac Monitor/12 Lead

D. Rapid transport to NIR capable facility

When a prehospital assessment yields a RACE score of 5 or higher, it strongly suggests a large vessel occlusion stroke, where rapid access to endovascular therapy can make a major difference in outcome. If blood glucose is within 60–400 mg/dL, you don't need to delay for glucose management, so the priority is speed to definitive care. The optimal action is rapid transport to a facility capable of neuro-interventional radiology, where imaging and potential thrombectomy can be performed without delay. Pre-arrival notification to activate the stroke/neuroradiology team is helpful to streamline care upon arrival.

2. If seizures persist after magnesium sulfate in a pregnant patient, what is the maximum initial dose of midazolam?

A. 5 mg

B. 2 mg

C. 10 mg

D. 1 mg

When seizures continue after magnesium sulfate in a pregnant patient, you need a fast-acting medication to stop the seizure while keeping the patient hemodynamically stable. Midazolam is used because it acts quickly and has a short enough duration to allow ongoing monitoring and airway management if needed. The maximum initial dose is 5 mg given by IV push. This amount is sufficient to rapidly abort seizures in most cases without the excessive sedation and respiratory depression that a larger dose might cause upfront. After this initial dose, additional dosing can be given per protocol if seizures persist, but starting with 5 mg balances effectiveness with safety. Always be ready to support breathing and airway, and monitor the mother closely, since both maternal and fetal status can be affected during seizure activity.

3. What is the fluid bolus for an AMS pediatric patient with BgL >60 mg/dl?

A. Oxygen therapy

B. Dextrose 5% IV

C. NS or LR 20 mL/kg IV/IO; may repeat up to 60 mL/kg

D. NS or LR 20 mL/kg IV/IO; may repeat up to 60 mL/kg; if BgL >250, then 10 mL/kg bolus

When a pediatric patient with altered mental status has a blood glucose not in the hypoglycemic range (greater than 60 mg/dL), the priority is to address potential poor perfusion with an isotonic fluid bolus rather than giving glucose or treating with oxygen alone. The standard approach is an isotonic crystalloid—normal saline or lactated Ringer's—given at 20 mL/kg via IV or IO, and you may repeat to a total of 60 mL/kg based on the patient's response. If the blood glucose is very high (above 250 mg/dL), an additional 10 mL/kg bolus is indicated to support hydration and perfusion. Dextrose-containing fluids are not used when glucose is above 60 mg/dL, since they would worsen hyperglycemia. Oxygen can be provided as needed, but it does not substitute for fluid resuscitation in this scenario. So the best choice reflects giving an isotonic fluid bolus of 20 mL/kg, with the possibility of repeating up to 60 mL/kg, and adding an extra 10 mL/kg if BG exceeds 250 mg/dL.

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4. Which of the following is NOT an approved vagal maneuver?

A. Valsalva maneuver

B. Head-down tilt with deep inspiration

C. Activation of the diving reflex by facial immersion in ice water (unless ischemic heart disease is present)

D. Administration of adenosine

Vagal maneuvers work by increasing parasympathetic (vagal) tone to slow conduction through the AV node and help terminate certain supraventricular tachycardias. The Valsalva maneuver accomplishes this by raising intrathoracic pressure and triggering a reflex increase in vagal activity, which slows AV conduction. Head-down tilt with deep inspiration also augments vagal tone and can provoke bradycardia through similar reflex pathways. The diving reflex, induced by cold facial immersion, promotes vagal output to the heart via a trigeminal-triggered reflex, producing bradycardia. Administration of adenosine, however, is a pharmacologic action that directly blocks AV nodal conduction through receptor pathways, causing a brief pause in AV conduction to terminate SVT. It does not rely on increasing vagal tone, so it is not an approved vagal maneuver.

5. Before performing vagal maneuvers, what must be in place?

A. Oxygen saturation above 95 percent

B. The patient must be hemodynamically stable

C. The patient must be attached to a cardiac monitor and have vascular access

D. Defibrillation equipment must be checked and ready

The main point is safety through monitoring and quick access for intervention. Before you attempt vagal maneuvers, the patient should be on continuous cardiac monitoring and have reliable IV access. Monitoring lets you see how the rhythm responds to the maneuver—whether the AV node slows, whether the rhythm converts to NSR, or if it deteriorates into another rhythm. IV access is essential so you can rapidly administer medications if needed (for example, adenosine or other drugs) or fluids, and you can escalate to synchronized cardioversion quickly if the patient becomes unstable. Oxygenation and general stability are important, but they don't by themselves guarantee a safe run of a vagal maneuver like monitoring and access do. Defibrillation equipment should be ready, but the prerequisite that directly enables safe execution and rapid management is having the patient monitored with IV access in place.

6. Which of the following is an NIR capable center in Las Vegas?

A. Mount Charleston General

B. Paradise Valley Medical Center

C. Sunrise

D. Riverside Valley Hospital

Neuro-interventional radiology centers provide urgent endovascular treatment for neurovascular emergencies, especially acute ischemic stroke from large vessel occlusion. They have a dedicated interventional suite and a 24/7 team to perform procedures like mechanical thrombectomy and other endovascular interventions, which can dramatically reduce disability when time is critical. Sunrise Hospital and Medical Center in Las Vegas is the facility that maintains a true NIR program with round the clock availability, making it the designated NIR capable center for the area. The other hospitals either do not offer neuro-interventional radiology services or aren't established as Las Vegas-based NIR centers, so they wouldn't be the appropriate destination for a patient needing those immediate neuroendovascular treatments.

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7. What is the maximum dose of diphenhydramine?

A. 25 mg

B. 50 mg

C. 75 mg

D. 100 mg

Diphenhydramine is given in EMS as an adjunct for allergic reactions, and the dose is limited per administration to balance benefit with potential anticholinergic and sedative side effects. In typical paramedic protocols, the maximum single dose is 50 mg, given by IM or IV. Doses of 50 mg provide the needed antihistamine effect without a disproportionate jump in adverse effects; increasing beyond 50 mg raises risks such as excessive drowsiness, confusion, urinary retention, tachycardia, and hypotension, with limited added therapeutic benefit in the acute prehospital setting. Therefore, 50 mg per dose is the appropriate maximum. Smaller doses (like 25 mg) may be used for sensitivity or pediatrics, but 50 mg remains the per-dose ceiling.

8. Stridor management references which protocol?

A. Chest pain ACS protocol

B. Seizure protocol

C. Pulmonary edema protocol

D. Allergic reaction protocol

Stridor signals upper airway narrowing from edema, which in EMS practice is most commonly caused by an allergic reaction or anaphylaxis. Because this airway compromise is addressed within the allergic reaction protocol, that protocol is the reference for managing stridor. The other protocols focus on unrelated scenarios: chest pain ACS targets cardiac ischemia, seizure protocol covers neurologic events, and pulmonary edema deals with fluid overload and lower airway symptoms. When stridor arises in the context of an allergic reaction, the emphasis is on protecting the airway and countering the reaction—epinephrine administration, airway monitoring, and readiness for advanced airway management, with additional adjuncts as indicated.

9. Postpartum symptoms of preeclampsia/eclampsia may present after delivery for up to how long?

A. 48 hours

B. 2 weeks

C. 3 months

D. Up to 6 weeks

Preeclampsia and eclampsia can develop after delivery, and the postpartum period extends about six weeks. Because factors that promote endothelial dysfunction can linger after the placenta is gone, blood pressure elevations and related symptoms may first appear at any point during that puerperal window. That makes six weeks the appropriate timeframe for postpartum symptom onset. While many cases occur early—within days—the risk window isn't limited to 48 hours or two weeks; a minority may develop symptoms up to six weeks postpartum. Three months postpartum is outside the typical surveillance period. If symptoms such as severe headaches, vision changes, epigastric pain, or sudden high blood pressure occur after delivery, urgent evaluation is needed.

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10. What should be given for mild to moderate pain?

A. Ibuprofen

B. Morphine

C. Ketamine

D. Acetaminophen 1 g IV/IO

Acetaminophen given IV or IO at 1 gram is the preferred first-line option for mild to moderate pain because it provides reliable analgesia without the respiratory depressive effects or heavy sedation associated with opioids. Its safety profile makes it suitable for a broad range of patients, including those where NSAIDs or sedatives pose more risk or where rapid IV/IO onset is helpful when oral dosing isn't possible. While other agents can be useful in certain situations (NSAIDs like ibuprofen have GI and renal risks; morphine is a strong opioid reserved for more painful cases; ketamine offers dissociative analgesia but can cause side effects and isn't routinely first-line for mild pain), acetaminophen 1 g IV/IO is a safe, effective initial choice for mild to moderate pain in prehospital care.

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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:

https://snhdparamedicprotocol.examzify.com

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

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