

CLINICALJUDGE™ • MASTER STUDY GUIDE

PEDIATRIC EMERGENCIES

Every pediatric emergency the 2026 NGN NCLEX-RN can test — respiratory, cardiovascular, neurologic, GI/fluid, hematologic/oncologic, and toxicologic — with pathophysiology, hallmark cues, the priority intervention and first action, medications, and the must-know fact for each. Built to take you to 100%.

2026 NGN BLUEPRINT

~35 EMERGENCIES

RESPIRATORY • CARDIAC • NEURO • GI • HEME • TOX

PRIORITIES & FIRST ACTIONS

AGE-BASED VITALS & FLUIDS

RED
CRITICAL CUES

BLUE
PATHOPHYSIOLOGY

GREEN
PRIORITY ACTIONS

ORANGE
COMPLICATIONS

YELLOW
MUST-KNOW FACT

PURPLE
MEDICATIONS

TEAL
TEACHING



THE PEDIATRIC GOLDEN RULE

Children arrest from respiratory failure, not primary cardiac causes — so airway/breathing is almost always the priority. And **hypotension is a LATE sign of shock in kids**; they compensate with tachycardia until they crash. Act on early signs (tachypnea, tachycardia, retractions, restlessness).

01

PEDIATRIC ASSESSMENT FOUNDATIONS

HOW KIDS DIFFER • WHAT TO ACT ON

PEDIATRIC ASSESSMENT TRIANGLE (PAT)

RAPID "ACROSS-THE-ROOM" EVALUATION

THREE SIDES

- Appearance** — tone, interactiveness, consolability, look/gaze, cry (overall neuro/perfusion)
- Work of breathing** — retractions, nasal flaring, grunting, position, sounds
- Circulation to skin** — color, pallor, mottling, cyanosis

KEY

Forms a first impression in seconds; abnormal appearance + work of breathing = respiratory distress trending toward failure.

RECOGNIZING SHOCK EARLY

COMPENSATED VS DECOMPENSATED

CUES

COMPENSATED (EARLY)

Tachycardia, normal BP, cool extremities, ↑cap refill, mild ↓urine, irritability

DECOMPENSATED (LATE)

Hypotension, weak pulses, mottling, lethargy → arrest

PRIORITY

Isotonic fluid bolus **20 mL/kg** (repeat as needed); identify cause (dehydration is #1 in peds).

KEY

Hypotension is LATE — treat tachycardia & poor perfusion before BP falls.

DEHYDRATION ASSESSMENT

THE MOST COMMON PEDS FLUID EMERGENCY

CUES

Sunken fontanel, dry mucous membranes, no tears, tenting skin turgor, ↓/no wet diapers, sunken eyes, delayed cap refill, lethargy.

PRIORITY

- Mild–moderate → **oral rehydration solution (ORS)**
- Severe / shock → IV isotonic bolus 20 mL/kg
- Monitor **weight & urine output** (best indicators), I&O, electrolytes

KEY

Daily weight & urine output are the most reliable indicators of fluid status in children.

PEDIATRIC PAIN & DOSING

WEIGHT-BASED • AGE-APPROPRIATE TOOLS

PRINCIPLES

- Pain scales:** FLACC (preverbal/infant), FACES (≥3 yr), numeric (older child)
- All dosing is weight-based** (mg/kg) — always verify weight
- No rectal temps/meds in neutropenic or immunocompromised children

KEY

Always recalculate doses against the child's weight; double-check high-alert pediatric meds.

02

RESPIRATORY EMERGENCIES

THE #1 CAUSE OF PEDIATRIC ARREST

EPIGLOTTITIS

BACTERIAL • TRUE EMERGENCY

CUES — THE 4 D'S

Drooling, Dysphagia, Dysphonia (muffled voice), Distress + tripod position, high fever, toxic/anxious appearance, inspiratory stridor.

PRIORITY

- 1 **Do NOT examine the throat / no tongue depressor** (can cause laryngospasm & total obstruction)
- 2 Keep child calm & upright; NPO; minimize stimulation
- 3 Have emergency airway equipment ready; prepare for intubation/tracheostomy; antibiotics

KEY

Never put anything in the mouth or upset the child; Hib vaccine prevents it.

CROUP (LARYNGOTRACHEOBRONCHITIS)

VIRAL • UPPER AIRWAY

CUES

Barking/seal-like cough, inspiratory stridor, hoarseness, low-grade fever, worse at night; gradual onset.

PRIORITY

- 1 Keep child calm; **cool humidified air/mist**
- 2 **Nebulized racemic epinephrine** for stridor at rest
- 3 Corticosteroids (dexamethasone); monitor for worsening

KEY

Barking cough + stridor = croup (managed at home/cool mist); contrast with toxic, drooling epiglottitis.

BRONCHIOLITIS / RSV

INFANTS • LOWER AIRWAY

CUES

Wheezing, tachypnea, retractions, nasal flaring, copious secretions, poor feeding; **apnea risk in young infants**.

PRIORITY

- 1 **Nasopharyngeal suctioning** (clears obstruction, eases feeding/breathing)
- 2 O₂ hydration, elevate HOB; **contact + droplet precautions**
- 3 Supportive care; palivizumab prophylaxis for high-risk infants

KEY

Suctioning before feeds is high-yield; RSV is highly contagious — strict hand hygiene/isolation.

STATUS ASTHMATICUS

SEVERE REFRACTORY BRONCHOSPASM

CUES

Severe dyspnea, accessory muscle use, prolonged expiration; **silent chest / diminishing wheeze = ominous** (airway closing).

PRIORITY

- 1 High-Fowler's, O₂, continuous monitoring
- 2 Nebulized **albuterol** ± ipratropium
- 3 Systemic corticosteroids; IV magnesium; prepare to intubate if failing

KEY

A quieting chest is worsening, not improving — escalate immediately.

FOREIGN BODY ASPIRATION (CHOKING)

AGE-SPECIFIC TECHNIQUE

CUES

Sudden coughing/choking, stridor, drooling, cyanosis; toddlers (small objects/food).

PRIORITY

- 1 Effective cough → encourage coughing (don't intervene)
- 2 **Infant (<1 yr)**: 5 back blows + 5 chest thrusts
- 3 **Child (≥1 yr)**: abdominal thrusts (Heimlich)
- 4 Unconscious → CPR; look in mouth before breaths (no blind sweeps)

KEY

No abdominal thrusts in infants; no blind finger sweeps (push object deeper).

RESPIRATORY DISTRESS → FAILURE

RECOGNIZING DECOMPENSATION

CUES

DISTRESS (COMPENSATING)

Tachypnea, retractions, nasal flaring, grunting, head bobbing, restlessness

FAILURE (IMPENDING ARREST)

Bradypnea, ↓breath sounds, cyanosis, lethargy, bradycardia

PRIORITY

Position, O₂, support ventilation; **act before failure** — restlessness/irritability is an early hypoxia sign.

KEY

Bradycardia + decreasing effort = pre-arrest in a child — intervene urgently.

03

CARDIOVASCULAR EMERGENCIES

RHYTHM • SHUNTS • PERFUSION

HYPERCYANOTIC "TET" SPELL

TETRALOGY OF FALLOT

PATHO

↑Right-to-left shunt → ↓pulmonary flow → acute hypoxemia/cyanosis (crying, feeding, stress)

CUES

Sudden deep cyanosis, irritability, hyperpnea; older children instinctively squat.

PRIORITY

- 1 **Knee-chest position** (↑systemic resistance → ↓shunt) — first action
- 2 Calm the child; O₂
- 3 Morphine, IV fluids; notify provider

KEY

Knee-chest position first during a tet spell.

SUPRAVENTRICULAR TACHYCARDIA (SVT)

INFANT HR OFTEN >220, CHILD >180

CUES

Very fast, narrow-complex rate; poor feeding, irritability, pallor, signs of HF if prolonged.

PRIORITY

- 1 **Vagal maneuvers** — ice/cold pack to the face (infant), bear-down (older child)
- 2 **Adenosine** rapid IV push if vagal fails
- 3 Synchronized cardioversion if unstable

MEDS Adenosine

KEY

Ice to the face is the classic infant vagal maneuver; adenosine is given fast with an immediate flush.

HEART FAILURE IN INFANTS

CONGENITAL DEFECT COMPLICATION

CUES

Feeding difficulty, diaphoresis with feeds, poor weight gain, tachycardia, tachypnea, hepatomegaly, periorbital edema.

PRIORITY

- 1 Small, frequent feeds; upright; cluster care/conserves energy
- 2 Digoxin (check apical HR; hold per parameter), diuretics, ACE inhibitors
- 3 O₂; monitor daily weight & I&O

KEY

Sweating & tiring during feeds is an early infant HF sign; check apical HR before digoxin.

KAWASAKI DISEASE

VASCULITIS • CORONARY ANEURYSM RISK

CUES

Fever >5 days, strawberry tongue, cracked/red lips, bilateral conjunctivitis, rash, edema & peeling of hands/feet, cervical lymphadenopathy.

PRIORITY

- 1 **IVIG + high-dose aspirin** (one of the few peds aspirin indications)
- 2 Monitor cardiac status (echocardiogram) for coronary aneurysm
- 3 Watch for HF; assess for irritability/comfort

KEY

Coronary aneurysm is the feared complication — cardiac monitoring is essential.

PEDIATRIC SHOCK

HYPOVOLEMIC IS MOST COMMON

CUES

Tachycardia (earliest), cool/mottled skin, ↑cap refill, ↓urine, irritability → lethargy; **hypotension is late**.

PRIORITY

- 1 Airway/O₂; **isotonic bolus 20 mL/kg**, reassess, repeat
- 2 Identify cause (dehydration, sepsis, hemorrhage, anaphylaxis)
- 3 Vasopressors if fluid-refractory; antibiotics early for septic shock

PEDIATRIC CARDIAC ARREST

USUALLY RESPIRATORY IN ORIGIN

PRIORITY

- 1 High-quality CPR — **15:2 with 2 rescuers** (30:2 single rescuer), compress ½ AP chest depth
- 2 Epinephrine; treat reversible causes; defibrillate shockable rhythms
- 3 Prioritize oxygenation/ventilation (the common precipitant)

KEY

Because arrests are usually respiratory, **effective ventilation is critical** in pediatric resuscitation.

04

NEUROLOGIC EMERGENCIES

SEIZURES • INFECTION • INTRACRANIAL PRESSURE

FEBRILE SEIZURE

6 MONTHS-5 YEARS • RAPID TEMP RISE

CUES

Brief generalized tonic-clonic seizure with fever; usually benign & self-limited.

PRIORITY

- 1 Protect from injury; **side-lying position**; nothing in mouth; don't restrain
- 2 Antipyretics; treat the fever source
- 3 Reassure caregivers; teach seizure first aid

KEY

Most febrile seizures are benign; protect airway & manage fever — not an automatic epilepsy diagnosis.

STATUS EPILEPTICUS

SEIZURE >5 MIN OR NO RECOVERY BETWEEN

PRIORITY

- 1 Protect airway, side-lying, O₂ suction; **nothing in mouth, don't restrain**
- 2 Check glucose; IV/IO **benzodiazepine** (lorazepam/diazepam; IN/rectal midazolam if no access)
- 3 Load antiepileptic (levetiracetam/fosphenytoin); identify cause

MEDS Lorazepam Diazepam (rectal) Midazolam (IN)

KEY

Airway/safety first; benzodiazepine is the first-line drug to stop the seizure.

BACTERIAL MENINGITIS

INFECTION OF MENINGES

CUES

INFANT

Bulging fontanel, high-pitched cry, poor feeding, irritability/lethargy, opisthotonos, fever

OLDER CHILD

Nuchal rigidity, +Kernig/Brudzinski, headache, photophobia, fever, AMS; petechial rash (meningococcal)

PRIORITY

- 1 **Droplet precautions** immediately
- 2 Antibiotics ASAP (after cultures/LP — don't delay treatment)
- 3 Quiet/dark room, seizure precautions, monitor ICP

KEY

Petechiae/purpura + fever = meningococcemia (rapidly fatal) → isolate & treat immediately.

INCREASED INTRACRANIAL PRESSURE

INFANT SIGNS DIFFER FROM OLDER CHILD

CUES

Infant: bulging fontanel, separated sutures, ↑head circumference, high-pitched cry, "setting-sun" eyes. **Older**: headache, vomiting, ↓LOC, diplopia. Late = Cushing's triad.

PRIORITY

- 1 HOB 30°, head midline/neutral; minimize stimulation/clustering
- 2 Manage fever & pain; avoid hypercapnia; osmotic therapy (mannitol/hypertonic saline)
- 3 Monitor LOC & pupils; prevent ↑intrathoracic pressure

KEY

A **bulging fontanel** is a hallmark of ↑ICP in infants; ↓LOC is the earliest change at any age.

REYE'S SYNDROME

ENCEPHALOPATHY + HEPATIC DYSFUNCTION

PATHO

Viral illness + aspirin → acute encephalopathy + fatty liver → ↑ICP, ↑ammonia

CUES

Following a viral illness: persistent vomiting, lethargy → confusion/combativeness → seizures/coma; ↑LFTs/ammonia.

PRIORITY

Supportive care, monitor ICP/ammonia/glucose, seizure precautions.

KEY

Never give aspirin to children with viral illness (chickenpox/flu) — prevents Reye's.

HEAD TRAUMA & ABUSIVE HEAD TRAUMA

RECOGNIZE & REPORT

CUES

Head injury → ↓LOC, vomiting, unequal pupils. **Abusive head trauma (shaken baby):** retinal hemorrhages, subdural bleed, seizures with **no external injury & an inconsistent history.**

PRIORITY

- 1 Stabilize ABCs & C-spine; neuro monitoring for ↑ICP
- 2 Recognize injuries inconsistent with the stated mechanism/development
- 3 **Mandatory reporting** of suspected abuse; ensure child safety

KEY

Suspicious or inconsistent injuries = **mandatory report**; nurses are mandated reporters.

05

GI & FLUID EMERGENCIES

OBSTRUCTION • VOMITING • METABOLIC

PYLORIC STENOSIS

2-8 WEEK INFANT

CUES

Projectile, non-bilious vomiting after feeds; hungry afterward; **olive-shaped RUQ mass**; dehydration; hypochloremic, hypokalemic metabolic alkalosis.

PRIORITY

- 1 **Correct fluid/electrolyte imbalance first**
- 2 NPO/NG decompression; then surgical **pyloromyotomy**
- 3 Post-op: small frequent feeds, monitor for vomiting

KEY

Rehydrate & correct alkalosis/hypokalemia **before** surgery.

INTUSSUSCEPTION

3 MONTHS-3 YEARS • BOWEL TELESOPING

CUES

Sudden severe **colicky intermittent pain** (draws knees up), "**currant-jelly**" stools (blood + mucus), sausage-shaped mass, bilious vomiting (late).

PRIORITY

- 1 **Air/contrast enema** (diagnostic and often therapeutic — may reduce it)
- 2 Surgery if enema fails or perforation
- 3 Report passage of a normal brown stool (may indicate reduction)

KEY

Currant-jelly stool is the classic sign; sudden normal stool may mean it reduced.

MALROTATION / VOLVULUS

SURGICAL EMERGENCY

CUES

Bilious (green) vomiting in an infant, abdominal distention, pain, signs of obstruction/ischemia.

PRIORITY

NPO, NG decompression, IV fluids; **emergent surgery** (bowel ischemia risk).

KEY

Bilious vomiting in an infant is a surgical emergency until proven otherwise.

APPENDICITIS

RUPTURE/PERITONITIS RISK

CUES

RLQ pain (McBurney's), rebound tenderness, fever, anorexia, N/V, ↑WBC. **Sudden pain relief = rupture.**

PRIORITY

- 1 NPO, IV fluids, pain control; appendectomy
- 2 **No heat, no laxatives, no enemas** (rupture risk)
- 3 Monitor for peritonitis post-rupture

PEDIATRIC DKA

TYPE 1 DIABETES CRISIS

CUES

Hyperglycemia, ketones, metabolic acidosis, **Kussmaul respirations**, fruity breath, dehydration, abdominal pain, ↓LOC.

PRIORITY

- 1 **IV fluids first** (isotonic) to restore volume
- 2 IV regular insulin infusion; replace **potassium**
- 3 **Correct glucose slowly** — children are at high risk of cerebral edema

KEY

Watch for cerebral edema (headache, ↓LOC) during correction — a leading cause of DKA death in children.

GASTROENTERITIS WITH DEHYDRATION

VOMITING/DIARRHEA • FLUID LOSS

CUES

Diarrhea, vomiting, dehydration signs (see foundations); electrolyte imbalance, metabolic acidosis.

PRIORITY

- 1 **Oral rehydration solution** for mild-moderate; IV for severe
- 2 Contact precautions; monitor weight/I&O/electrolytes
- 3 Avoid antidiarrheals; reintroduce normal diet as tolerated

KEY

ORS is first-line; avoid sugary drinks/plain water alone (worsen electrolyte loss).

06

HEMATOLOGIC & ONCOLOGIC EMERGENCIES

SICKLE CELL • NEUTROPENIA • BLEEDING

SICKLE CELL CRISIS (VASO-OCCLUSIVE)

HBS • VASO-OCCLUSION

PATHO

Trigger (dehydration, hypoxia, cold, infection, stress, acidosis) → RBCs sickle → vaso-occlusion → ischemia & severe pain

PRIORITY

- 1 Hydration + oxygen + pain control (opioids — don't undertreat)
- 2 Keep warm; treat/prevent infection; rest
- 3 Hydroxyurea (chronic); avoid known triggers

KEY

Hydration, O₂, and pain control are the core; **cold & dehydration trigger crises**.

ACUTE CHEST SYNDROME & SPLENIC SEQUESTRATION

SICKLE CELL LIFE-THREATS

CUES

ACUTE CHEST

Chest pain, fever, cough, hypoxia, infiltrate — leading cause of death

SPLENIC SEQUESTRATION

Rapid splenic enlargement, sudden ↓Hgb, hypovolemic shock

PRIORITY

Acute chest → O₂, hydration, antibiotics, transfusion. Sequestration → fluids/blood for shock; teach parents to palpate spleen & seek care.

KEY

Acute chest syndrome & sequestration are emergencies — respiratory distress or sudden pallor/shock needs immediate care.

FEBRILE NEUTROPENIA

ONCOLOGY EMERGENCY • ANC <500

CUES

Fever in a neutropenic child = **emergency** (may be the only sign of life-threatening infection).

PRIORITY

- 1 Blood cultures, then **broad-spectrum antibiotics within 1 hour**
- 2 **Neutropenic precautions**; no rectal temps/meds/suppositories
- 3 Monitor for sepsis; consider G-CSF (filgrastim)

KEY

Fever + neutropenia → don't wait; antibiotics within the hour after cultures.

BLEEDING DISORDERS & TUMOR LYSIS

HEMOPHILIA/ITP • POST-CHEMO METABOLIC

CUES

Hemophilia → **hemarthrosis**, prolonged bleeding. ITP → petechiae/bruising. Tumor lysis → **↑K, ↑phosphate, ↑uric acid, ↓calcium** → renal failure/dysrhythmia.

PRIORITY

- 1 Hemophilia → factor replacement, RICE, **no aspirin/NSAIDs, no IM/contact sports**
- 2 Bleeding precautions; tumor lysis → hydration + allopurinol/rasburicase, monitor electrolytes

07

TOXICOLOGIC & ENVIRONMENTAL EMERGENCIES

INGESTIONS • ALLERGY • BURNS

POISONING / INGESTION (GENERAL)

LEADING PEDIATRIC INJURY

PRIORITY

- 1 Support ABCs; identify the substance, amount, and time
- 2 **Call Poison Control**; supportive care; activated charcoal for select ingestions
- 3 Give the specific antidote; **do NOT induce vomiting** (ipecac no longer used)

KEY

No syrup of ipecac; never induce vomiting with caustics or hydrocarbons (aspiration/burn risk).

COMMON SPECIFIC INGESTIONS

ANTIDOTES TO KNOW

CUES

Acetaminophen (mild early → hepatotoxic), **iron** (GI + shock; lethal in toddlers), **caustics/hydrocarbons** (oral/airway burns, aspiration).

ANTIDOTES

- 1 Acetaminophen → **N-acetylcysteine**
- 2 Iron → **deferoxamine** (chelation)
- 3 Caustics/hydrocarbons → **do not induce vomiting**; dilute/airway support, endoscopy

KEY

Iron poisoning is a common, deadly toddler ingestion — keep supplements out of reach.

LEAD POISONING

CHRONIC EXPOSURE • NEUROTOXIC

CUES

Often insidious: developmental delay, ↓cognition/behavior changes, abdominal pain, anemia; sources = old paint/dust, water.

PRIORITY

- 1 Screen blood lead level; remove the exposure source
- 2 **Chelation therapy** (succimer, EDTA, dimercaprol) for elevated levels
- 3 Nutritional support (iron/calcium); environmental teaching

KEY

Prevention & source removal are central; neurologic damage can be irreversible.

ANAPHYLAXIS

TYPE I HYPERSENSITIVITY

CUES

Rapid: stridor/wheeze, throat/lip swelling, urticaria, hypotension, GI cramps, sense of doom.

PRIORITY

- 1 **IM epinephrine** (anterolateral thigh) — first and immediate
- 2 Remove trigger; airway, high-flow O₂; supine with legs up
- 3 IV fluids; antihistamines/corticosteroids/bronchodilators as adjuncts

KEY

Epinephrine first — not antihistamines or steroids; teach auto-injector use.

PEDIATRIC BURNS

↑BSA-TO-WEIGHT • GREATER FLUID LOSS

CUES

Airway risk (facial/inhalation), large fluid shifts, hypothermia; **consider non-accidental injury** (immersion/pattern burns).

PRIORITY

- Airway first**; stop the burning process; assess extent
- Fluid resuscitation (greater needs per weight), pain control, warmth
- Infection prevention; evaluate burn pattern for abuse & report if suspicious

DROWNING & SEPSIS

SUBMERSION INJURY • MENINGOCOCCEMIA

CUES

Drowning → hypoxia, possible C-spine injury, delayed respiratory deterioration. Sepsis/meningococemia → fever, **petechiae/purpura**, shock.

PRIORITY

- Drowning → airway/ventilation, C-spine protection, rewarm; monitor for delayed pulmonary edema
- Sepsis → cultures, **antibiotics within 1 hour**, fluid resuscitation, isolation

KEY

After a submersion event, watch for **delayed respiratory compromise** even if the child seems fine.



MASTER REFERENCE TABLES

THE CONSOLIDATED HIGH-YIELD DATA

08 · PEDIATRIC VITAL SIGNS BY AGE (APPROXIMATE)

AGE	HEART RATE (BPM)	RESPIRATORY RATE	NOTES
Newborn	100–160	30–60	Highest rates; lowest BP
Infant (1–12 mo)	90–160	30–53	Apnea/feeding cues matter
Toddler (1–3 yr)	80–130	22–37	Common ingestions/choking age
Preschool (3–5 yr)	80–120	20–28	FACES pain scale appropriate
School age (6–12 yr)	70–110	18–25	Approaching adult ranges
Adolescent (≥13 yr)	60–100	12–20	Adult ranges

Rates trend **down** and BP trends **up** with age. Hypotension is a late sign at any age.

09 · DEHYDRATION SEVERITY

SIGN	MILD	MODERATE	SEVERE
Weight loss	~3–5%	~6–9%	≥10%
Mucous membranes	Slightly dry	Dry	Parched/cracked
Fontanel (infant)	Normal	Slightly sunken	Markedly sunken
Tears / cap refill	Present / <2 s	↓ / 2–3 s	Absent / >3 s
Mental status	Alert	Irritable	Lethargic
Management	ORS	ORS	IV bolus 20 mL/kg

10 · RESPIRATORY DISTRESS VS FAILURE

PARAMETER	DISTRESS (COMPENSATING)	FAILURE (IMPENDING ARREST)
Respiratory rate	Tachypnea	Bradypnea / apnea
Effort	Retractions, flaring, grunting, head bobbing	Decreasing effort, gasping
Breath sounds	Wheeze/stridor present	Diminished / silent
Color	Pink/pale	Cyanosis
Mental status / HR	Restless/irritable, tachycardic	Lethargic, bradycardic

11 · INCREASED ICP — INFANT VS OLDER CHILD

INFANT	OLDER CHILD
Bulging/tense fontanel	Severe headache
Separated cranial sutures, ↑head circumference	Vomiting (often projectile)
High-pitched cry, irritability	Diplopia, blurred vision, papilledema
"Setting-sun" eyes, poor feeding	↓LOC, behavior change

Both, late: Cushing's triad (↑SBP with widening pulse pressure, bradycardia, irregular respirations), fixed/dilated pupils, posturing

12 · COMMON INGESTIONS & ANTIDOTES

SUBSTANCE	ANTIDOTE / MANAGEMENT
Acetaminophen	N-acetylcysteine (NAC)
Iron	Deferoxamine (chelation)
Lead	Succimer / EDTA / dimercaprol
Opioids	Naloxone
Benzodiazepines	Flumazenil (cautious)
Caustics / corrosives	Do NOT induce vomiting/neutralize; dilute, airway, endoscopy
Hydrocarbons	Do NOT induce vomiting (aspiration pneumonitis)

13 · PEDIATRIC FLUID RESUSCITATION & MAINTENANCE

CONCEPT	RULE
Resuscitation bolus	20 mL/kg isotonic (NS/LR), reassess, repeat as needed
Maintenance (4–2–1)	4 mL/kg/h (first 10 kg) + 2 mL/kg/h (next 10 kg) + 1 mL/kg/h (each kg >20)
DKA fluids	Isotonic first, then insulin + K ⁺ ; correct slowly (cerebral edema)
Best fluid–status indicators	Daily weight & urine output
Urine output goal	~1–2 mL/kg/h (infants/children)

PEDIATRIC EMERGENCY MASTERY CHECKLIST

SELF-CHECK BEFORE TEST DAY

I CAN CONFIDENTLY...

- | | |
|--|---|
| ☒ Explain why respiratory failure (not cardiac) usually precedes pediatric arrest | ☒ Recognize compensated shock and that hypotension is a late sign |
| ☒ Manage epiglottitis: keep calm, NPO, no throat exam, prepare for airway | ☒ Distinguish croup (barking cough, mist) from epiglottitis (drooling, toxic) |
| ☒ Prioritize suctioning, O ₂ , and isolation in RSV/bronchiolitis | ☒ Apply age-specific choking interventions (infant back blows/chest thrusts) |
| ☒ Use knee–chest position first for a tet spell | ☒ Treat SVT with vagal maneuvers (ice to face) then adenosine |
| ☒ Recognize Kawasaki and the coronary aneurysm risk (IVIG + aspirin) | ☒ Manage seizures/status epilepticus (airway, side-lying, benzodiazepine) |
| ☒ Identify meningitis & ICP signs in infants vs older children | ☒ Avoid aspirin in children with viral illness (Reye's) |
| ☒ Recognize abusive injury and fulfill mandatory reporting | ☒ Assess dehydration and choose ORS vs IV bolus (20 mL/kg) |
| ☒ Identify pyloric stenosis, intussusception, and bilious vomiting (volvulus) | ☒ Correct pediatric DKA slowly and watch for cerebral edema |
| ☒ Manage sickle cell crisis (hydration, O ₂ , pain) and recognize acute chest | ☒ Treat febrile neutropenia urgently (cultures + antibiotics within 1 h, no rectal temps) |
| ☒ Match common ingestions to antidotes and never induce vomiting | ☒ Give epinephrine first in anaphylaxis and apply weight-based dosing throughout |

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