



Notes/Definitions

- Hypoglycemia in pediatrics is a significant emergency.
- Potential causes for Altered Level of Consciousness (ALOC) in pediatric patients may include: seizure, stroke, hypoglycemia, hyperglycemia, overdose / ingestion, trauma, and shock.

Base Hospital Contact Required

BLS Interventions

- Refer to OCEMS General BLS Standing Orders SO-BLS.

ALS Interventions

- Assess Pediatric Assessment Triangle (PAT)
 - General appearance: tone, interactiveness, consolability, look / gaze, speech / cry
 - Work of breathing: retractions, nasal flaring, abnormal airway sounds, positioning
 - Circulation to skin: pallor, mottling, cyanosis
- When BLS airway management cannot maintain adequate ventilation or oxygenation and criteria met, consider:
 - Supraglottic airway insertion for ≥ 50 kg (PR-135)
 - Endotracheal intubation for > 36 kg (PR-030)
- Apply capnography (EtCO₂) as tolerated.
 - Maintain EtCO₂ between 35 and 45 mmHg
 - If EtCO₂ > 50 : ensure proper positioning for adequate ventilation and suction as needed.
 - If no improvement, initiate BVM.
- Obtain the patient's estimated weight utilizing an appropriate length-based resuscitation tape or age-based system.
- Initiate cardiac monitor as needed. Interpret, monitor, and document rhythm.
- Obtain IV / IO access if applicable.
- If blood glucose < 60 , administer one of the following:
 - ▶ **Glucagon 0.5 mg IM** - once
 - ▶ **10% Dextrose 5 mL / kg IV / IO** (maximum dose 250 mL)
*avoid oral glucose due to high aspiration risk
- Assess GCS. Use pediatric GCS for patients aged ≤ 2 years (Refer to B-002).
- If hypotensive (refer to Vital Sign table below), administer:
 - ▶ **Normal Saline 20 mL / kg IV / IO** (maximum dose 250 mL).
 - For continued hypotension, may repeat the same dose twice for total of three boluses.
- If narcotic toxicity is suspected with respiratory depression, bradypnea, and / or pinpoint pupils,



administer:

▶ **Naloxone (Narcan ®)**

- **0.1 mg / kg IN or IM** (maximum 1 mg), may repeat every 3 minutes
- **0.1 mg / kg IV** (maximum 1 mg), may repeat every 3 minutes
- **4 mg / 0.1 mL** preloaded nasal spray IN, may repeat every 3 minutes
- Determine if patient meets pediatric stroke criteria (refer to OCEMS Treatment Guideline P-115).
- If a seizure is suspected, refer to OCEMS Treatment Guideline P-075.

Transport Consideration

- **Base Hospital Contact** required (CCERC preferred).
- ALS escort to nearest open ERC (or as directed by Base Hospital).

Additional Considerations

- A seizure lasting longer than 5 minutes or multiple seizures without recovery or return to normal mental status between episodes is considered status epilepticus and is a neurological emergency.
- Not all pediatric seizure patients will present with tonic-clonic seizure activity. Subclinical seizure may present as abnormal vital signs, gaze deviation, and clenched jaw.
 - Abnormal vital signs include: hypoventilation (shallow and/or slow respirations for age), tachycardia for age, and hypoxia.
- Avoid use of oral glucose as material placed in mouth may be aspirated if recurrent seizure occurs.
- Post-ictal patients with a low GCS (<9) need careful airway monitoring.
- Simple Febrile Seizures:
 - Ages 6 months to 5 years with fever and seizure activity and typically present as generalized tonic-clonic seizure.
 - These seizures are due to a sudden rise in body temperature that disrupts normal brain activity.
 - A febrile seizure becomes a neurological emergency if the seizure meets the status epilepticus definition. These patients should be directed to a CCERC.

Pediatric Vital Signs by Age

Age	Pulse	Systolic Blood Pressure	Respiratory Rate
Neonate (0-30 days)	100-180	> 60	30-60
Infant (31 days - < 1 yr)	100-160	> 60	30-60
Toddler (1 yr - < 3 yrs)	90-150	> 70	24-40
Pre-school (3 yrs - < 5 yrs)	80-140	> 75	22-34
School Aged (5 yrs - < 10 yrs)	70-120	> 80	18-30
Teen (≥ 10 yrs)	60-100	> 90	12-16

Approved:

Review Date: 05/16, 11/16, 05/17, 10/19, 04/26

Final Date for Implementation: 04/01/2027



ORANGE COUNTY EMERGENCY MEDICAL SERVICES

Prehospital Standing Orders / Treatment Guidelines

ALTERED MENTAL STATUS - PEDIATRIC

#: P-065

Page: 3 of 3

Original Date: 11/86

Revised: 10/01/2026

Base Hospital

- Diabetic ketoacidosis can present as altered mental status in the pediatric population, if suspected order a Normal Saline bolus once.
- There are multiple potential causes for altered mental status in children, consider these potential etiologies in the field setting:
 - Hypoxia
 - Hypoglycemia
 - Occult injury (particularly closed head injury)
 - Sepsis with poor cerebral perfusion
 - Poisoning (medications or other toxins)
 - Anaphylaxis with poor cerebral perfusion
 - Carbon monoxide toxicity
 - Hypovolemia due to fluid loss (such as vomiting / diarrhea)
 - Seizure, atypical
 - Meningitis / encephalitis

Cross References:

SO-BLS General BLS Standing Orders

BLS Procedure B-002 (Glasgow Coma Scale Score)

P-075 Pediatric Seizure

P-115 Pediatric Stroke

ALS Procedure PR-030 Endotracheal Intubation (including EtCO₂)

ALS Procedure PR-135 Supraglottic Airway Device Placement – Adult/Adolescent

Approved:

A handwritten signature in black ink, appearing to read "Shaikh MD".

Review Date: 05/16, 11/16, 05/17, 10/19, 04/26

Final Date for Implementation: 04/01/2027