

Basic first aid and when to call emergency



Start with safety, assessment, and help

In any pediatric first aid situation, pause for a brief scene assessment. A calm, structured approach protects both you and the child. Look for ongoing hazards such as traffic, fire, electrical exposure, broken glass, aggressive animals, water, chemicals, or a collapsing structure. Do not become a second casualty. If the area is unsafe and you cannot make it safe quickly, call emergency services and follow dispatcher instructions.

Use a simple sequence: danger, response, airway, breathing, circulation, and disability. Check whether the child responds to voice or gentle stimulation. If the child is unresponsive, shout for help and ask a specific person to call emergency services and bring an automated external defibrillator if one is available. If you are alone with a mobile phone, call on speaker mode so you can continue care.

Open the airway with care. If there is no concern for trauma, a gentle head tilt and chin lift may help. If trauma is possible, avoid excessive neck movement and follow dispatcher guidance. Look, listen, and feel for normal breathing. Gasping, irregular agonal breaths, or no breathing should be treated as not breathing normally. Call emergency services immediately and begin CPR if

trained, or follow dispatcher-assisted CPR instructions.

Next, look for catastrophic bleeding. Severe external bleeding can kill quickly and should be controlled with direct pressure. Reassure the child in short, concrete phrases. Children often mirror adult distress, so a steady voice helps even when you feel frightened. Continue to monitor breathing, skin color, level of consciousness, and worsening pain while waiting for help.

When to call emergency services immediately

Call emergency services now if a child is unresponsive, not breathing normally, has severe breathing difficulty in children, is turning blue or gray, has severe or uncontrolled bleeding, is choking and cannot cough effectively, or has signs of shock such as pallor, cold clammy skin, profound weakness, confusion, or collapse. Do not delay the call to perform prolonged first aid; activation of emergency care is itself a life-saving intervention.

Other pediatric emergency warning signs include a first seizure in a child, a seizure lasting several minutes, repeated seizures, a seizure associated with breathing problems or injury, altered mental status in children, a non-blanching rash with fever, severe dehydration, suspected poisoning in a child, major burns, electrical injury, near-drowning, significant head trauma, neck or spine injury, or a child who looks seriously ill to you.

Call rather than drive if the child may deteriorate on the way, needs CPR, has severe respiratory distress, has a possible spinal injury, is actively seizing, has major bleeding, or is too drowsy to protect the airway. Emergency dispatchers can guide immediate actions, send the right level of response, and advise whether moving the child is safe.

For less urgent but concerning problems, a same-day call to the pediatrician or urgent care may be appropriate. Examples may include a small cut with controlled bleeding, mild burn, minor sprain, low-grade fever in an otherwise well older child, or a brief nosebleed that stops with pressure. However, if your concern is that something is seriously wrong, trust that concern and seek immediate help.

Choking and breathing emergencies

Choking is a time-critical airway emergency. First determine whether the child is coughing effectively. If the child can cough, cry, or speak, encourage coughing and monitor closely. Do not put fingers into the mouth unless you can clearly see and safely remove an object; blind finger sweeps can push the object deeper.

If the child cannot breathe, cough, cry, or speak, call emergency services and begin age-appropriate choking first aid if trained. For infants, recommended techniques differ from those for older children, so formal first aid training is strongly encouraged. If the child becomes unresponsive, lower them carefully to a firm surface, call emergency services if not already done, and begin CPR. Each time the airway is opened, look for a visible object, but do not sweep blindly.

Breathing difficulty can also come from asthma, infection, anaphylaxis, trauma, aspiration, or other causes. Warning signs include severe work of breathing, grunting, pauses in breathing, inability to speak or feed because of breathlessness, retractions, cyanosis, exhaustion, or unusually quiet breathing after previous distress. If asthma rescue medication is prescribed and not helping as expected, or if distress is severe, call emergency services.

Keep the child in the position that makes breathing easiest unless there is an immediate need for CPR or protection from danger. Do not force a distressed child to lie flat. Avoid offering food or drink during significant respiratory distress because aspiration risk may be increased. Stay with the child and be ready to begin CPR if breathing stops or becomes abnormal.

Bleeding, wounds, burns, and eye injuries

For bleeding, expose the wound enough to see where blood is coming from. Apply firm, direct pressure with a clean cloth, dressing, or your gloved hand if available. Maintain continuous pressure. If blood soaks through, add more material on top rather than repeatedly removing the original dressing, which may disrupt clot formation. Call emergency services for uncontrolled bleeding in a child, spurting blood, deep wounds, amputation, embedded objects, or signs of shock.

Do not remove large embedded objects. Stabilize them with bulky dressings and seek emergency care. For minor wounds, rinse visible dirt with clean running water when safe, cover with a sterile dressing, and seek medical advice about tetanus risk, bite wounds, deep punctures, wounds over joints, or signs of infection. Do not apply unverified substances to wounds.

For burns, stop the burning process first. Remove the child from heat, turn off electricity if safe, and remove loose clothing or jewelry near the burn unless stuck to the skin. Cool the burn under cool running water for about 20 minutes as soon as possible. Avoid ice, butter, toothpaste, oils, or adhesive dressings. Cover with a clean non-stick dressing or clean plastic film if appropriate and seek urgent care for burns involving the face, hands, feet, genitals, major joints, large areas, chemical or electrical burns, inhalation concerns, or burns in very young children.

For chemical exposure to skin or eyes, brush away dry chemicals if safe, then irrigate with copious clean water and call emergency services or poison advice as directed locally. For eye injuries, do not rub the eye, do not remove embedded objects, and seek urgent assessment for chemical exposure, penetrating injury, visual change, severe pain, or persistent foreign body sensation.

Head injury, falls, fractures, and spinal precautions

Children fall often, and many minor bumps are not dangerous. The challenge is recognizing when a fall may involve intracranial injury, cervical spine injury, or significant musculoskeletal trauma. Call emergency services after major trauma, a fall from significant height, high-speed collision, suspected non-accidental injury, loss of consciousness, seizure after injury, worsening headache, confusion, abnormal behavior, weakness, repeated vomiting after a head injury, unequal pupils, or fluid or blood from the nose or ears after trauma.

If you suspect head, neck, or spinal injury, minimize movement. Encourage the child to stay still and support the head in the position found if you can do so safely. Do not twist the neck to check injuries. Move the child only if there is immediate danger, such as fire, traffic, or submersion. If vomiting occurs and you are worried about the airway, follow dispatcher guidance; protecting breathing takes priority, but unnecessary spinal movement should be avoided.

For possible fractures or dislocations, look for deformity, swelling, severe pain, inability to use the limb, numbness, tingling, pale or cold extremity, or an open wound over a bone. Immobilize the limb in the position found if you can do so without increasing pain. Do not attempt to straighten a deformed limb or relocate a joint. Apply a cold pack wrapped in cloth for short periods if tolerated, and seek medical evaluation.

For sprains or minor limb injuries, rest, elevation, and protection from further injury may help while arranging care. However, young children may not localize pain well, and refusal to bear weight, persistent crying with movement, or pain over a growth plate should be assessed by a clinician.

Seizures, fainting, poisoning, and allergic reactions

During a seizure, protect the child from injury. Move hard objects away, cushion the head if possible, and note the time. Do not hold the child down and do not put anything in the mouth. When movements stop, place the child on their side if breathing normally and there is no major trauma concern. Call emergency services for a first seizure, a prolonged seizure, repeated seizures, breathing difficulty, injury, diabetes, pregnancy in an adolescent, water-related seizure, or failure to return toward baseline.

Fainting may occur with dehydration, pain, heat, emotional stress, or other causes, but collapse can also reflect cardiac, neurologic, metabolic, or toxic emergencies. If the child faints and does not wake promptly, has chest pain, palpitations, exertional collapse, abnormal breathing, cyanosis, severe headache, or a concerning medical history, call emergency services. If awake and breathing normally, lay the child flat if tolerated and monitor closely.

For suspected toxic ingestion, inhalation, or skin exposure, do not wait for symptoms. Call poison control or emergency services according to local guidance. Keep the container, plant, medication, or product label available. Do not induce vomiting unless specifically instructed by a poison specialist or emergency clinician.

Anaphylaxis can present with hives, swelling, vomiting, cough, wheeze, hoarseness, throat tightness, dizziness, collapse, or involvement of multiple

body systems after exposure to a trigger. If the child has a prescribed epinephrine auto-injector, use it according to the child's emergency plan and call emergency services immediately. Even if symptoms improve, medical observation is important because symptoms can recur.

Preparing before an emergency happens

Preparation reduces hesitation. Keep a first aid kit where caregivers can find it, and check it regularly. Useful contents include disposable gloves, sterile gauze, adhesive bandages, elastic bandage, non-stick dressings, tape, small scissors, tweezers, a digital thermometer, saline or clean water access for irrigation, instant cold pack, emergency blanket, and a written list of emergency contacts, allergies, medical conditions, and current medicines. Include prescribed emergency medicines only for the child for whom they were prescribed, and make sure trained caregivers know where they are kept.

Create a family pediatric emergency plan. Post the local emergency number, poison control number, pediatrician contact, preferred emergency department, and the child's key medical information. Share the plan with babysitters, relatives, school staff, coaches, and childcare providers. If your child has asthma, epilepsy, diabetes, severe allergy, heart disease, or another chronic condition, ask the clinician for a written action plan.

Consider certified pediatric first aid, CPR, and AED training. Skills such as chest compressions, rescue breaths, choking response, hemorrhage control, and AED use are easier to perform under stress if practiced. Refresh training periodically, because recommendations can change and memory fades.

Finally, after any emergency, care for the emotional aftermath. Children may need simple explanations, reassurance that adults are helping, and a return to routine when safe. Caregivers may also feel shaken. Debrief with healthcare professionals, update the emergency plan, replace used supplies, and seek support if the event was traumatic.