COMPANION GUIDE TO ONLINE TRAINING

Use alongside the online lessons at fortunefavorsthepreprepared.com/med-01-landing/

MED-01: MARCH-PAWS TACTICAL TRAUMA
STUDENT COMPANION GUIDE

The Responder's Field Reference

Hemorrhage Control, Airway, Respiration, Circulation, Hypothermia & Head Injury,
Pain Management, Antibiotics, Wound Care, and Splinting

M | A | R | C | H | P | A | W | S

Edition v1.0 | 2026

Semper Paratus, Semper Gumby

https://fortunefavorsthepreprepared.com/
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MED-01: MARCH-PAWS TACTICAL TRAUMA — STUDENT COMPANION GUIDE

Companion Guide to Online Training

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> *This companion guide is designed to be used alongside the MED-01 MARCH-PAWS Tactical Trauma online training series at fortunefavorstheprepared.com/med-01-landing/. The online lessons are the instruction. This guide contains quick-reference tables, field checklists, and decision frameworks only — it does not contain the full instructional content. It cannot be used as a standalone document.*

ONLINE TRAINING ACCESS

The seven online lessons are available online. Support the development and availability of these courses by subscribing to my Patreon:

patreon.com/fortunefavorstheprepared

INSTRUCTOR-LED GROUP TRAINING

Group sessions and facilitated training are available. Contact:

fortunefavorstheprepared@protonmail.com

How to Use This Companion Guide

THIS GUIDE IS A COMPANION TO THE ONLINE TRAINING

This companion guide is designed to be used alongside the MED-01 MARCH-PAWS Tactical Trauma online training series — the online lessons are the instruction. This guide contains quick-reference tables, field checklists, and decision frameworks only. It is not a standalone document.

Support the development and availability of these courses by subscribing to my Patreon: patreon.com/fortunefavorsthepreprepared

Online curriculum: fortunefavorsthepreprepared.com/med-01-landing/

What this guide contains

For each of the seven online lessons: a condensed reference summary (key concepts only, not instruction), quick-lookup tables, decision checklists, field reference cards, and advanced skill notices. The instruction is delivered online — this guide is what you carry during practical exercises and training scenarios.

Advanced skills are marked throughout with an amber warning block. These require formal training, clinical supervision, and in some cases medical licensure or prescription authority. They are included for recognition and handoff communication only. Do not attempt without documented training and authorization.

Required workflow — online lessons BEFORE using this guide

ORDER MATTERS

Do not open any section of this guide until the corresponding online lesson has been completed. The condensed summaries here are reference material, not instruction. The sequence below is required, not suggested.

- Step 1 — Support the development and availability of these courses by subscribing to my Patreon: patreon.com/fortunefavorsthepreprepared
- Step 2 — Access the online lessons at fortunefavorsthepreprepared.com/med-01-landing/
- Step 3 — Complete all seven lessons including knowledge checks
- Step 4 — Use this guide during practical exercises and active scenarios as a field reference

THIS GUIDE IS NOT STANDALONE

The instruction for each lesson is delivered through the online training series. This guide contains condensed reference tables and checklists only. If you have not completed the online lessons, this guide will not teach you the material — it will give you tables whose meaning you do not yet understand.

Guide Map — What to Reference When

When you need...	Turn to...
The MARCH-PAWS sequence at a glance	Part I — Sequence Reference
Hemorrhage control decision steps	Part II — M: Massive Hemorrhage
Airway intervention hierarchy	Part II — A: Airway
Chest wound and tension pneumothorax signs	Part II — R: Respiration
Shock recognition without equipment	Part II — C: Circulation & Shock
Hypothermia prevention and rewarming	Part II — H: Hypothermia & Head Injury
TBI red flags and AVPU scale	Part II — H: Hypothermia & Head Injury
Pain management options and contraindications	Part II — P: Pain Management
Antibiotic indications and documentation	Part II — A: Antibiotics
Wound irrigation and dressing selection	Part II — W: Wounds
Splinting technique and neurovascular check	Part II — S: Splinting
Critical numbers and vital sign thresholds	Part III — Quick Reference
Common failure modes by phase	Part III — Failure Mode Catalogue
Blank patient assessment worksheet	Part IV — Worksheets
Doctrinal sources	Part IV — Doctrinal Sources

PART I — SEQUENCE REFERENCE

The MARCH-PAWS Framework

MARCH-PAWS is the doctrinal framework for life-threat management in austere and disaster environments. The sequence is non-negotiable: it exists to override the instinct to treat what is most visible or loudest, and replace it with a disciplined assessment of what is most immediately lethal.

MARCH addresses immediate life threats in order of lethality. PAWS begins only after all of MARCH is complete, and sustains the patient through prolonged care until evacuation or definitive care is available.

M	A	R	C	H	P	A	W	S
Massive Hemorrhage	Airway	Respiration	Circulation	Head/Hypothermia	Pain	Antibiotics	Wounds	Splinting

Letter	Full Name	Core Action	Key Principle
M	Massive Hemorrhage	Control life-threatening bleeding; conduct blood sweep	Address before everything else. #1 cause of preventable death.
A	Airway	Ensure airway is open and protected	Speaking = patent. Snoring/gurgling = intervene immediately.
R	Respiration	Identify and treat breathing compromise	Seal open chest wounds with vented dressing. Recognize tension pneumothorax pattern.
C	Circulation	Assess and treat hemorrhagic shock	Treat signs, not numbers. Don’t wait for BP to fall.
H	Head / Hypothermia	Protect brain; prevent heat loss	Warmth is hemorrhage management. Lucid interval = red flag.
P	Pain	Manage pain to preserve function	PAWS begins only after MARCH is complete.
A	Antibiotics	Prevent infection when indicated	Contaminated wounds only — not routine.
W	Wounds	Clean, cover, reassess	Volume of irrigation matters more than solution.
S	Splinting	Immobilize to stop ongoing damage	Joint above and below. Check neurovascular before and after.

PART II — PHASE-BY-PHASE REFERENCE

M Massive Hemorrhage

MED-01-01 — Address before Airway, before everything

Recognize Life-Threatening Bleeding

- Bright red spurting blood (arterial) or dark red blood rapidly soaking clothing
- Amputation or near-amputation
- Rapidly deteriorating mental status without obvious cause
- Blood pooling at high-risk sites: neck, axilla, groin, inner thigh

Tourniquet — Extremity Bleeding

- Apply high and tight — top of the limb, not adjacent to the wound
- Apply over clothing if under time pressure
- Tighten until bleeding stops completely and distal pulse is absent
- If bleeding persists: apply second tourniquet immediately above
- Mark time on forehead — never cover the tourniquet
- Tourniquet in place ≥6 hours: do not remove — physician decision at definitive care

Partial tourniquet = false sense of control. Tighten fully or it is failing.

Wound Packing — Junctional / Non-Extremity

- Junctional sites: neck, axilla, groin — tourniquet cannot reach
- Pack deeply with hemostatic gauze (Combat Gauze, Celox) or plain gauze
- Maintain firm, uninterrupted pressure for minimum 3 minutes
- Apply pressure dressing over packed wound
- Neck: direct pressure only — no circumferential wrap

Blood Sweep — Before Moving to Airway

- Neck → both axillae → both groins → arms → legs → chest → abdomen → back
- Feel for warm, wet sensation under clothing
- Address any new hemorrhage found before proceeding

A Airway

MED-01-02 — After hemorrhage is controlled

Assess

- Speaking in full sentences = patent airway (reassess as condition changes)
- Snoring = tongue obstruction — intervene
- Gurgling = fluid in airway — clear it
- Stridor = partial upper obstruction
- Cyanosis = inadequate oxygenation
- CSF from nose or ears = basilar skull fracture — NPA contraindicated

Interventions (Simplest First)

- **Recovery position:** no suspected spinal injury, unconscious but breathing
- **Head tilt / chin lift:** no suspected spinal injury
- **Jaw thrust:** suspected spinal injury or head tilt failed — two hands required
- Clear visible obstruction: roll to side, direct removal, suction — no blind finger sweep

ADVANCED SKILL — QUALIFIED PROVIDERS ONLY
NPA insertion, supraglottic devices, and surgical cricothyroidotomy require formal hands-on training and appropriate authorization. Described below for recognition and handoff communication only. Do not perform without documented training.

NPA Overview

- Sized: tip of nose to earlobe
- Insert bevel toward septum, straight back along nasal floor — not upward
- **Contraindicated:** CSF draining from nose or ears (basilar skull fracture)
- Tolerated by semiconscious patients who would gag on oral airway

Breathing casualty ≠ safe airway. Reassess at every interval.

R Respiration

MED-01-03 — After airway is managed

Assess

- Normal rate: 12–20 breaths/min; deviation requires explanation
- Look: symmetrical chest rise? visible wounds? flail chest segment?
- Listen: equal breath sounds both sides? Absent one side = pneumothorax or hemothorax
- Sucking sound on inhalation from chest wound = open chest wound — seal immediately

Open Chest Wound — Seal Immediately

- **Use vented chest seal** (HyFin, Halo) or 3-sided occlusive dressing
- 3-sided tape: top, left, right sealed — bottom edge open as vent
- Seal both entry and exit wounds if present
- If casualty deteriorates after sealing: lift one edge to vent trapped air
- Improved when lifted: tension building — reseal with vent open

Never apply a fully sealed non-vented dressing to a chest wound.

Tension Pneumothorax — Recognize the Pattern

- Absent breath sounds on affected side
- Worsening respiratory distress not improving with airway maneuvers
- Declining mental status after chest injury
- Late signs: tracheal deviation away from affected side, distended neck veins
- Context: chest trauma, or deterioration after chest seal applied

ADVANCED SKILL — QUALIFIED PROVIDERS ONLY
Needle thoracostomy requires formal clinical training and authorization. Included for recognition only.
If untrained: vent the chest seal and evacuate urgently.

C Circulation & Shock

MED-01-04 — Recognize hemorrhagic shock without equipment

AVPU Scale

Level	Response	Clinical Significance
A — Alert	Responds normally, oriented to person/place/time	Normal baseline — establish and monitor
V — Verbal	Responds to voice only, not fully oriented	Declining — suggests hemorrhage or TBI
P — Pain	Responds only to painful stimulus	Serious deterioration — treat aggressively
U — Unresponsive	No response to any stimulus	Decompensated or critically injured

Shock Signs Without Equipment

- **Pulse >100 bpm:** tachycardia, red flag in any trauma casualty
- **Radial pulse present:** systolic BP likely >80 mmHg
- **Radial absent, carotid present:** BP likely <80 mmHg — late shock
- **Pale, cool, clammy skin:** peripheral vasoconstriction
- **Capillary refill >2 seconds:** impaired peripheral circulation
- **Restlessness, anxiety:** early hypoxia from blood loss
- **AVPU declining:** decompensation may be imminent

Stable-appearing casualty with tachycardia and pale skin is in shock. Do not wait for BP to fall.

Field Management

- Confirm all bleeding controlled — return to M if new source found
- Position flat; elevate legs if no pelvic or lower limb fracture
- **Wrap for warmth:** hypothermia worsens coagulopathy = more bleeding
- Reassess every 5 minutes; evacuate urgently

ADVANCED SKILL — QUALIFIED PROVIDERS ONLY

IV/IO access and fluid administration require clinical training and authorization. If trained and authorized: permissive hypotension — titrate small boluses (250–500 mL) to maintain mentation and radial pulse. Do not target normal BP. Do not give fluids to unconscious casualty.

H Hypothermia & Head Injury

MED-01-05 — The lethal triad and TBI recognition

The Lethal Triad

- Hypothermia + Acidosis + Coagulopathy = mutually reinforcing killers
- Any hemorrhagic shock casualty is at risk regardless of ambient temperature
- Normal core temp: 37°C / 98.6°F; mild hypothermia begins at <35°C / 95°F

Rewarming

- **Passive:** remove wet clothing, insulate above AND below, space blanket reflective side in
- **Active:** heat packs in axillae and groin — wrapped, no direct skin contact
- Do NOT apply heat to extremities — causes dangerous afterdrop

Warmth is hemorrhage management, not comfort. It preserves the clotting mechanism.

See also: MED-03 DCAP-BTLS Secondary Assessment for detailed neurological exam. MED-06 Patient Care Documentation for TBI findings on the TCCC card.

Head Injury — Red Flags

- Unequal pupils or pupils not reacting to light
- One-sided weakness or paralysis
- CSF from nose or ears (clear fluid)
- Significant facial or skull deformity
- Seizure with no prior history
- **Lucid interval then deterioration:** red flag for expanding intracranial hemorrhage — evacuate urgently

TBI + Shock: Treat Both

- Hypotension dramatically worsens TBI outcomes
- Treat hemorrhagic shock aggressively even with concurrent head injury
- Head elevated 30° only after hemorrhage controlled and spinal injury excluded

Lucid interval = deceptively normal then rapid deterioration. Do not dismiss.

PART II CONTINUED — PAWS: SUSTAINING THE PATIENT

PAWS begins only after all of MARCH is complete — no exceptions. Starting any PAWS intervention while a MARCH step is incomplete diverts attention from the immediately lethal problem.

P — Pain Management

MED-01-06 — Begins only after all of MARCH is complete

OTC Options — Civilian Scope

Agent	Dose	Notes
Acetaminophen	500–1000 mg	Safe for hemorrhagic casualties. First choice when bleeding is a concern.
Ibuprofen	400–800 mg	AVOID in hemorrhagic casualties — inhibits platelet function
Aspirin	—	AVOID in hemorrhagic casualties — same platelet concern

Documentation

- Record: drug name, dose, route, time
- Report at every handoff
- Reassess mental status and RR after administration

ADVANCED SKILL — QUALIFIED PROVIDERS ONLY

Prescription analgesics including opioids require a valid prescription and prescriber authorization. Included for completeness and handoff communication only.

Never give opioids to: a casualty who cannot protect their own airway, or who has altered mental status from head injury.

A Antibiotics

MED-01-06 — Indicated by wound type, not routine

Indications

- Open fractures (bone exposed through skin)
- Gunshot wounds (debris along the tract)
- Animal or human bites
- Wounds contaminated with soil, debris, or fecal material
- Wounds with significant devitalized tissue

Documentation

- Record: drug name, dose, route, time, indication
- Report at every handoff — prior antibiotics affect dosing at receiving facility

ADVANCED SKILL — QUALIFIED PROVIDERS ONLY

Prescription antibiotics require medical authority. Field expedient agents require a valid prescription and authorization. Included for recognition and handoff communication only.

If you lack authority: irrigate, cover, monitor for infection signs, and evacuate urgently.

See MED-06 for TCCC card documentation of antibiotic administration.

W Wounds

MED-01-06 — Clean, cover, reassess

Irrigation

- Copious clean water or saline — volume matters more than solution
- Moderately contaminated: minimum 200–500 mL
- Pressurized (syringe) more effective than pouring
- Remove visible surface debris only — no deep exploration

Dressing

- Most wounds: clean dry dressing with gentle pressure
- High infection-risk: moist (saline-soaked gauze) dressing
- **Do NOT remove** hemostatic packing from controlled hemorrhage wounds
- Reinforce outer dressing; note inner packing material at handoff

Reassess at Every Interval

- Increasing redness, warmth, swelling = early infection
- Purulent discharge = established infection
- Either finding: escalate antibiotics, increase evacuation urgency

Open Fractures

- Cover exposed bone with moist dressing before splinting
- Do NOT push bone back through skin
- Splint in position found; evacuate urgently
- Operative debridement required — not a field procedure

See MED-03 DCAP-BTLS Secondary Assessment for systematic wound documentation.

S Splinting

MED-01-06 — Immobilize to stop ongoing damage

Principle

- Immobilize joint above AND joint below the fracture
- Pad all bony prominences before securing
- Closed femur fracture can lose 1–2 L of blood into the thigh over hours

Improvised Splints

- Rigid material + padding + securing bandage
- SAM splint: lightweight, moldable, compact — carry one
- Traction splints for isolated femur fractures (not with vascular injury)

Neurovascular Check — Before and After

- **Circulation:** pulse in hand or foot distal to fracture
- **Sensation:** can casualty feel touch distal to fracture?
- **Movement:** can casualty move fingers or toes?
- Loss of pulse after splinting = too tight or fracture displaced — loosen immediately
- Recheck at every reassessment interval — swelling can compromise fit

> No post-splint neurovascular check is one of the most common PAWS errors.

PART III — QUICK REFERENCE

Critical Numbers and Thresholds

Metric	Normal / Threshold	Significance
Respiratory rate	12–20 breaths/min	Tachypnea or bradypnea in trauma requires explanation
Heart rate	>100 bpm = tachycardia	Red flag in any trauma casualty; early shock indicator
Capillary refill	<2 seconds normal	>2 sec = impaired peripheral circulation
Radial pulse present	Systolic BP likely >80 mmHg	Loss of radial = late shock, urgent intervention
Tourniquet time (safe)	Up to 2 hours warm ischemic	Mark time on forehead at application
Tourniquet time (removal)	≥6 hours = do not remove	Physician decision at definitive care only
Wound packing pressure	Minimum 3 minutes uninterrupted	Timer required — 3 min feels longer under stress
Core temp normal	37°C / 98.6°F	Mild hypothermia begins <35°C / 95°F
Fluid bolus (if authorized)	250–500 mL at a time, reassess	Target mentation + radial pulse, not normal BP

Failure Mode Catalogue

The most common errors in each phase — what the knowledge checks are designed to expose.

Phase	Common Failure Mode	Consequence
M	Tourniquet placed adjacent to wound, not high on the limb	Inadequate occlusion; continued hemorrhage
M	Tourniquet not fully tightened because casualty reports pain	Partial occlusion creates false sense of control while bleed continues
M	Blood sweep skipped	Concurrent hidden hemorrhage undetected until decompensation
M	Tourniquet covered by clothing or blanket	Missed by subsequent providers at handoff
M	Tourniquet attempted on junctional wound	Device cannot function; wound packing required instead
A	Breathing casualty assumed safe airway without reassessment	Deterioration missed; airway compromise identified late
A	NPA inserted when CSF present	Risk of device entering cranial vault
R	Chest wound sealed without a vent	Open pneumothorax converted to tension pneumothorax
R	Deterioration after sealing attributed to shock without venting	Tension pneumothorax allowed to progress
C	Treatment withheld until BP falls measurably	Decompensated shock; compensatory mechanisms exhausted
C	IV fluids titrated aggressively to normalize BP	Worsened coagulopathy; dilution of clotting factors
C	Warmth omitted as unnecessary comfort measure	Lethal triad: hypothermia worsens coagulopathy
H	Lucid interval dismissed as the casualty being uninjured	Expanding epidural hematoma unrecognized
H	Heat packs applied to extremities for rewarming	Afterdrop: acute drop in core temperature
H	Hemorrhagic shock undertreated because of concurrent head injury	Hypotension dramatically worsens TBI outcomes
PAWS	Pain management started before MARCH is complete	Attention diverted from active life threat
PAWS	Ibuprofen given to hemorrhagic casualty	Platelet inhibition worsens ongoing hemorrhage
PAWS	Opioids given to casualty with airway compromise or altered mental status	Respiratory depression added to existing problem

Phase	Common Failure Mode	Consequence
PAWS	Antibiotics given routinely to all trauma wounds	Indiscriminate use; no benefit for low-risk wounds
PAWS	Post-splint neurovascular check omitted	Vascular compromise or nerve injury goes undetected

PART IV — WORKSHEETS AND REFERENCES

MARCH-PAWS Assessment Worksheet

Use during practical exercises and scenario-based training. Complete in sequence. Do not advance to the next phase until the current one is assessed and treated.

Date / Time:	Scenario / Patient ID:	Responder:
_____	_____	_____

M	**Massive Hemorrhage**	Life-threatening bleeding identified? (Y / N / Location): _____ Tourniquet applied? (Y / N) Location: _____ Time: _____ Wound packing applied? (Y / N) Location: _____ Hemostatic agent: _____ Blood sweep completed? (Y / N) Additional bleeding found: _____
A	**Airway**	Airway status: Patent / Compromised / Threatened Intervention: None / Recovery position / Head tilt-chin lift / Jaw thrust / NPA / Other: _____ Breath sounds post-intervention: Clear bilateral / Abnormal: _____
R	**Respiration**	RR: _____ bpm Chest rise: Symmetrical / Asymmetrical Chest wounds: None / Open (sealed: Y/N Vented: Y/N) Tension pneumothorax signs: None / Present (action taken: _____)
C	**Circulation**	Pulse rate: _____ bpm Pulse quality: Strong / Weak / Absent radial Capillary refill: <2 sec / >2 sec Skin: Normal / Pale / Cool / Clammy AVPU: A / V / P / U Mental status trend: Stable / Declining Shock treatment: Position / Warmth / IV fluids (authorized: Y / N)
H	**Head / Hypothermia**	Temperature concern: None / Wet / Cold surface / Prolonged exposure Rewarming: Space blanket / Heat packs axillae / Heat packs groin / Remove wet clothing Head injury signs: None / Present: _____ Pupils: Equal reactive / Unequal: L_____ R_____ Lucid interval observed: Y / N TBI red flags: None / List: _____
P	**Pain**	Pain score (0–10): _____ Location: _____ Analgesic given: None / Acetaminophen / Ibuprofen / Prescription (authorized: Y / N) Drug: _____ Dose: _____ Route: _____ Time: _____
A	**Antibiotics**	Indication present: None / Open fracture / GSW / Bite / Contaminated wound Antibiotic given: None / Name: _____ Dose: _____ Time: _____
W	**Wounds**	Wounds addressed: None / List: _____ Irrigation: None / Volume: _____ mL Dressing: Dry / Moist / Pressure Hemostatic packing in place: Y / N Do not remove.
S	**Splinting**	Fractures identified: None / Location: _____ Splint applied: None / Improvised / SAM / Traction Pre-splint: Pulse Y/N Sensation Y/N Movement Y/N Post-splint: Pulse Y/N Sensation Y/N Movement Y/N

Evacuation priority: Immediate / Delayed / Minimal **ETA to care:** _____

Handoff to: _____ **Time:** _____

Notes: _____

Doctrinal Sources

Source	Publisher	Relevance
Tactical Combat Casualty Care (TCCC) Guidelines	Joint Trauma System / CoTCCC	Primary doctrinal source for MARCH-PAWS. Current guidelines at jts.health.mil.
DHS Austere Emergency Medical Support Field Guide	U.S. Department of Homeland Security	Civilian-adapted field protocols for austere environments.
CONTOMS TEMS Medic Handbook	Counter Narcotics and Terrorism Operational Medical Support Program	Tactical Emergency Medical Support protocols; source for exsanguinating hemorrhage and airway management procedures.
Layperson's Guide to Prolonged Casualty Care	Uniformed Services University / DoD	Non-credentialed providers in prolonged care scenarios. MARCH-PAWS sequence, shock management, and wound care.
Improvised Medicine: Providing Care in Extreme Environments, 2nd Ed.	Iserson, K.V. (McGraw-Hill)	Tourniquet construction, airway improvisation, and austere medicine.

Related Courses in This Series

MED-02	**Medical History — SAMPLE & OPQRST** History-taking framework giving context to every MARCH-PAWS finding. Chief complaint, allergies, medications, prior history, last oral intake, and events preceding the incident. fortunefavorstheprepared.com/med-02-landing/
MED-03	**DCAP-BTLS Secondary Trauma Assessment** Systematic head-to-toe physical examination after MARCH-PAWS is complete. Finds injuries the primary survey missed and documents them for continuity of care. fortunefavorstheprepared.com/med-03-landing/
MED-06	**Patient Care Documentation** TCCC card completion, MIST and SBAR handoff reports, and documentation standards for prolonged field care. Everything observed and done in MARCH-PAWS goes on the card. fortunefavorstheprepared.com/med-06-landing/

MARCH-PAWS is not about having perfect equipment or advanced certifications. It is about applying a disciplined, sequenced assessment under pressure — finding what is killing the casualty fastest and addressing it first, every time, without being distracted by what is loudest or most visible. That discipline is a skill. Skills require practice.

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