Episode Book

EPISODE #6416

Family First Aid Audiobook: Adults

PUBLISHED	2 November 2026 at 18:57 UTC
DURATION	1:02:56
LISTEN	myweirdprompts.com/episode/israeli-adult-first-aid-52668/
HOSTS	Corn, Herman, Hilbert, Dorothy
SCRIPT MODEL	anthropic/claude-sonnet-5.5
VOICES	chatterbox-regular (chatterbox-local)
PIPELINE	V5.26
BOOK GENERATED	3 November 2026 at 07:01 UTC

SYNOPSIS

First aid knowledge degrades quickly without regular review. Drawing directly from published adult emergency guidelines by Magen David Adom and United Hatzalah, this guide clarifies high-stakes interventions. It breaks down essential protocols for adult CPR, automated external defibrillators, choking, and the recovery position. It details critical common errors—such as delivering back blows to a choking adult, hesitating to deploy an AED, or over-ventilating during chest compressions—and offers concrete operational steps for bystanders.

TRANSCRIPT



Corn

Most people read a first aid guide once, nod along, and have lost it by the weekend. Daniel's point is that this is the real problem. Guidelines like these go stale in your head, so they need a refresh every few months, not one read-through that gets filed away. This one is built to be played again.



Herman

It's a run-through of Israeli first aid guidance for adults, taken from the published protocols of Magen David Adom and United Hatzalah. Twenty-eight protocols. The edition for children and infants is a separate episode, so everything here assumes an adult.



Hilbert

One light line before we start, and then we leave it alone. This is a refresher based on published guidance. It isn't official advice, and it doesn't replace a proper first aid course. In an emergency, you call one-oh-one.



Herman

The numbers, once, clearly. Magen David Adom, the ambulance service: one-oh-one. United Hatzalah, the volunteer first responders: twelve twenty-one. Police: one hundred. Fire and Rescue: one-oh-two. Home Front Command: one-oh-four. The Poison Information Center at Rambam, open twenty-four hours: zero four, seven seven seven, one nine zero zero. And for urgent care that is not an emergency, the Terem national line: one, five nine nine, five two zero, five two zero.



Hilbert

If you only keep one of those, it's the first. At three in the morning nobody is dialling Terem.



Herman

For each protocol we talk for a minute about what matters and what people get wrong, and then Dorothy reads the steps. Five groups: breathing and circulation, bleeding and trauma, medical, environment, and bites and stings. We'll announce each one so you can skip ahead.



Corn

Group one, then. Breathing and circulation. Nine protocols, and we start with the big one.



Herman

CPR for adults. In this protocol an adult is anyone twelve or older, found unresponsive and not breathing normally. That phrase "not breathing normally" includes gasping. Gasping is not normal breathing. It's a sign of cardiac arrest, and you treat it as one.



Corn

So the classic mistake is watching someone gasp and thinking, well, they're still breathing.



Herman

That's the first one. The second is delay: the guidance is blunt that you don't hold back the call to one-oh-one, because early activation is critical for survival. Third, people check for breathing too long: ten seconds, no more. Fourth, they pause the compressions, and any pause should stay under ten seconds. Fifth, they lean on the chest or push deeper than six centimetres. You want full recoil. And don't over-ventilate: each breath is one second, just enough to see the chest rise.



Hilbert

Ten seconds is barely long enough to unlock a phone.



Herman

Which is why you put the call on speaker. MDA dispatchers coach CPR in real time. Dorothy, take us through it.

D

Dorothy

First half. Call out, shake the shoulders gently, ask loudly, are you okay. If they respond, no CPR: assess them, give the first aid they need, call one-oh-one if medical help is needed. If not, check breathing for no more than ten seconds: chest rise, breath sounds, air on your cheek. Breathing normally means recovery position, call one-oh-one, watch their

D

Dorothy (continued)

breathing. Not breathing means call one-oh-one now. With someone else there, they call and fetch an AED while you start compressions. Alone, call first on speakerphone, then get an AED if one is close, then start. The exception is choking: do CPR first, then call. Person face up on a firm, flat surface. In extreme heat, shade is fine if it doesn't delay compressions, and put a barrier under them on hot asphalt or sand. Heel of one hand on the centre of the chest, on the breastbone between the nipples, other hand on top, fingers interlocked, arms locked straight, upper body weight, straight down. One hundred to one hundred twenty compressions a minute, five to six centimetres deep, about two to two point four inches. Full recoil, no leaning. If you're not trained in rescue breaths, that's hands-only: continuous compressions at the same rate, no stopping.



Hilbert

Second half, for the trained and willing.

D

Dorothy

After thirty compressions, head-tilt and chin-lift, pinch the nose, seal your mouth over theirs, and give two breaths, each over one second, enough to see the chest rise. If it doesn't rise, re-tilt and try again, and if it still doesn't, go back to compressions rather than keep trying. Thirty to two, five cycles in about two minutes. When the AED arrives, turn it on and apply the pads immediately: one under the right collarbone, the other under and to the left of the left breast, or one on the front and one on the back, following the diagram. If it advises a shock, everyone clear, press the button. Either way, resume CPR immediately, without waiting for the re-analysis at about two minutes. Reassess every two minutes, and with two trained rescuers, swap the compressor every two minutes in under ten seconds. Continue until MDA takes over, there are definite signs of life, the AED tells you to stop, or you physically can't go on. If they start breathing normally, stop, recovery position, keep watching. And hands off during analysis and shock.



Corn

The AED is the next stop, and it's the one people are most nervous about.



Herman

With reason, a bit. Nobody wants to press the button. The lesson is that the machine will not shock someone who doesn't need it. The protocol says it plainly: it cannot harm a person who does not need a shock.



Hilbert

A machine with better judgment than most of us in a crisis. Reassuring.



Herman

And it talks you through everything. This protocol defines an adult as age eight and above, or showing signs of puberty, which is a different line from the CPR protocol, and the child edition covers the rest. Call one-oh-one first and put it on speaker, because dispatch can find the nearest AED. MDA runs more than a thousand smart stands that the dispatch centre can unlock remotely. There's also the Eifo-Defi app for finding the nearest device, and by law large public spaces, around five hundred people or more, have to have one. Never wait for the AED to start. Dorothy, the steps, please.

D

Dorothy

Confirm: unresponsive, no normal breathing within ten seconds. Conscious and breathing normally, no AED. Unconscious but breathing, recovery position and call. Otherwise call one-oh-one on speaker, start CPR as before, thirty to two if trained and willing, compressions only if not, and send someone for the AED. If you're alone and it's within a few seconds' reach, fetch it, otherwise keep going. Open the cover. Most models power on by themselves, some need the button, and it speaks. Bare the chest, cut away clothing including a bra, and dry it. Lots of hair: shave the pad areas with the kit razor. Medication patch: remove it and wipe the skin. Pacemaker or implanted defibrillator, a visible lump under the skin: pads at least two and a half centimetres, one inch, away. Metal surface: move them off it, or make sure nobody touches the metal during the shock. Pad one below the right collarbone to the right of the breastbone, pad two on the left side below the armpit, in line with the nipple, not touching each other. Plug in the cable if the pads aren't pre-connected. Hands off during analysis. If a shock is advised, call out, stand clear, press when told. Some models fire automatically. Back to CPR for two minutes, then it re-analyses. Repeat until paramedics arrive or they show life. If they do, recovery position, but keep the pads on and the AED running. Never turn it off or pull the pads. Not on someone in water or a puddle: move them, dry the chest. Not near flammable gases or oxygen-enriched air. And don't hold off defibrillation to wait for EMS: every minute of delay cuts survival by roughly seven to ten percent.



Corn

Seven to ten percent a minute. Sounds like a reason to stop reading this and go find the box.



Herman

Choking next, and the lesson here is to do nothing at first.



Corn

Nothing? That sounds wrong for a first aid episode.



Hilbert

If the person can cough forcefully and speak, you do not intervene. Coughing is the body's most effective defence, and abdominal thrusts on someone who is coughing can worsen the obstruction or injure them. Watch closely, be ready, and wait. Signs of a complete blockage: grasping the neck, no speech or cough, a face going red or blue, high-pitched wheezing.



Corn

And everyone's instinct is to slap them on the back.



Herman

For an adult, don't. The MDA protocol explicitly calls back blows on an adult incorrect and potentially harmful. No water either, no liquid of any kind, and no blind finger sweeps. Dorothy, over to you.

D

Dorothy

Ask, are you choking, can you speak? If they can cough and speak, wait and watch. If not, tell a bystander to call one-oh-one now. Alone, treat first, then call as soon as possible. Pregnant, very obese, or in a wheelchair? Use chest thrusts instead: hands on the centre of the breastbone, thrust firmly, and a wheelchair user stays seated. Otherwise abdominal thrusts: stand behind them, arms round the waist, fist with the thumb side above the navel and below the breastbone, other hand over it, rapid forceful thrusts inward and upward, as if lifting them. Reassess after each set. If it comes out and they can breathe, stop and still get a medical check, because thrusts can injure. If they lose consciousness, stop thrusts, lower them to the ground, call one-oh-one if not done, and start CPR, thirty compressions, two breaths. Before each set of breaths, look in the mouth. A visible object, remove it carefully. Nothing visible, no sweep. And if you're alone and choking, lean over a chair back or counter edge and press your upper abdomen hard against it, again and again, and call one-oh-one when you can speak.



Corn

Recovery position, the one everyone half remembers. This is for a person who is unresponsive, breathing, and has no suspected spinal injury. The most important rule sits on the other side of the same coin as CPR: if they are not breathing, you do CPR instead. Recovery position is only for a breathing casualty.



Herman

And not on their back.



Hilbert

Not on their back, because of the risk of the airway blocking and vomit or fluid getting into the lungs. And never leave them alone: monitor breathing continuously. Always call one-oh-one, because an unconscious person always needs professional evaluation.



Corn

What about a possible spinal injury?



Hilbert

If it's suspected, from a fall from height, a road accident, a blow to the head or neck, a dive, or neck or back pain, don't move them unless they're in immediate danger, like fire or drowning. If movement is unavoidable, support the head and neck in line with the body. Over to Dorothy for the run-through.

D

Dorothy

Call out, tap the shoulders. If they respond, no recovery position. If not, look in the mouth, tilt the body and clear visible food, dentures or vomit. Check breathing, ten seconds at most. Not breathing, CPR. Breathing, call one-oh-one and report an unconscious but breathing casualty. Kneel beside them. Near arm out at a right angle, palm up. Far arm across the chest, back of the hand against the near cheek, hold it. Bend the far knee to a right angle, and roll them toward you by pulling on it. Adjust the top leg so hip and knee are both at right angles. Tilt the head back slightly and adjust the hand under the cheek to hold it. Monitor breathing, clear the mouth if they vomit, keep them warm. If they stop breathing, roll onto the back and start CPR. After thirty minutes in position, turn them to the other side.



Herman

Heart attack, the protocol with the aspirin, which is where the mistakes live. The picture: pressure, tightness, heaviness or burning in the middle of the chest, possibly spreading to the arms, neck, jaw, back or upper abdomen, with breathlessness, cold sweat, nausea. It can also show up atypically, especially in women, as extreme fatigue, upper back pain, or something like heartburn.



Corn

So "it's just heartburn" is the thing people say, and the thing to doubt.



Hilbert

The guidance says don't dismiss the symptoms and don't wait to see if they pass, because every minute increases irreversible damage to the heart muscle. And two more: don't drive them to the hospital yourself. Call one-oh-one and wait, because the ambulance has cardiac monitoring and can start treatment on the way. And don't give food or drink.



Corn

Driving yourself feels like the productive option.



Herman

It does. Dorothy, walk us through it.

D

Dorothy

Call one-oh-one first, say you suspect a heart attack, stay on the line. Someone else can also call twelve twenty-one for United Hatzalah. No activity at all: not even a walk to the bathroom, because even minor effort raises the heart's oxygen demand. Half-sitting, back supported, knees slightly bent, or on their side if they prefer. Loosen collar, belt, tie. Calm, and cool and shaded in the heat. Ask about aspirin allergy. If allergic, no aspirin, and tell the MDA crew. Otherwise one hundred to three hundred milligrams, chewed, not swallowed whole. In Israel the usual tablet is one hundred milligrams, so one to three. Paracetamol, Acamol, is no substitute. Nitroglycerin only if they have their own prescription, and then help them take it as their doctor directed. Never anyone else's. Stay with them and watch consciousness, breathing and skin colour. Send someone for an AED, but don't apply it unless they become unresponsive and stop breathing normally. If they collapse, check response and breathing, and start CPR: at least five centimetres

D

Dorothy (continued)

deep, one hundred to one hundred twenty a minute, full recoil, thirty to two if trained, hands-only if not. Then the AED and its prompts.



Hilbert

Stroke is next, and the abbreviation is the one most people actually remember. FAST. Face, arm, speech, time. Ask the person to smile and look for one-sided drooping. Ask them to raise both arms and watch for one drifting down. Listen for slurred speech or trouble forming words. And time: note exactly when the symptoms began. The guidance says that even a single one of these signs is enough to call one-oh-one at once.



Herman

Not "let's see if it passes."



Corn

That's the big don't. Even if symptoms fade, which may be a transient ischemic attack, the person still needs emergency evaluation, because about forty percent of those patients go on to a full stroke within three months. And don't give food, drink or any medication. That includes aspirin. About fifteen percent of strokes are caused by bleeding, and aspirin or blood thinners can make that worse. That's a decision for medical professionals.



Herman

Which is the opposite of the heart attack rule, and exactly the sort of thing you'd mix up in a panic.



Corn

It is. Heart attack, chewed aspirin. Stroke, nothing by mouth. Dorothy, read us the steps.

D

Dorothy

Assess with FAST. Call one-oh-one immediately, and don't drive them unless truly unavoidable, because the crew notifies the stroke team and starts assessment on the way. The treatment window is about six hours from onset, with hospital arrival targeted within sixty minutes. Record the exact onset time, because it matters for clot-dissolving treatment. If they went to sleep fine and woke with symptoms, onset is when they went to sleep. Conscious: lie them down, head slightly raised and supported. Vomiting or at risk of it: on their side, recovery position. Unconscious but breathing: recovery position. Not breathing: CPR. Loosen scarves, ties, collars. Stay and watch. When the paramedics arrive, give them the onset time, which signs you saw, whether anything changed, and medications and history if you know them.



Hilbert

Asthma is mostly quick, with one fork. Sit them upright or leaning slightly forward, and do not lay them down. Stay with them, speak calmly, because anxiety makes the spasm worse. The key mistakes: laying them down, leaving them alone, trying controller medication for acute relief, which doesn't work immediately, and ignoring a silent chest.



Corn

A silent chest sounds like good news.



Herman

It's the opposite. Obvious distress with no wheezing means almost no air is moving, and that's life-threatening. Dorothy, you have the floor.

D

Dorothy

Ask about a rescue inhaler, Ventolin. None: call one-oh-one at once and keep reassuring them. Otherwise give it immediately, two to four puffs, operating it for them if needed, ideally with a spacer, a merkhav, which improves delivery a lot. Wait several minutes. Better: keep watching, repeat two to four puffs if it returns. Not better: repeat two to four puffs, and if still no improvement, call one-oh-one. Call straight away if they can't speak in full sentences, lips or fingertips go blue, they lose consciousness, or the chest is silent. Keep them upright until help arrives. If they lose consciousness and stop breathing, CPR. Even partial improvement still needs a medical evaluation.



Corn

Anaphylaxis, the one with the pen. The main lesson is speed with the epinephrine. It's the only effective first-line treatment, and the guidance says don't delay it if you suspect anaphylaxis. Antihistamines like diphenhydramine are not a substitute.



Hilbert

So the antihistamine in the cupboard is the wrong tool.



Herman

Not for this. Anaphylaxis means involvement of breathing, circulation or consciousness: hives, swelling of the face, lips, tongue or throat, wheezing, a weak rapid pulse, pallor, confusion, vomiting. A mild localised rash or itching with nothing systemic, you watch closely, no epinephrine, and call one-oh-one if it worsens.



Hilbert

What if they've had the injection and look fine?



Corn

Still hospital. Epinephrine lasts roughly twenty minutes and symptoms can return, so all suspected anaphylaxis needs hospital evaluation. Dorothy, take us through it.

D

Dorothy

Call one-oh-one at once, on speaker, and follow the dispatcher. Try to identify the allergen and remove it: scrape a bee stinger out sideways, stop an infusion, move them away. With face or tongue swelling assume the airway is at risk: clear food from the mouth, loosen tight clothing at the neck and chest. Breathing trouble is the main symptom: sit them upright. Low blood pressure is the main symptom: lay them down with legs raised. Never make someone with low blood pressure stand or sit up suddenly, because it can cause cardiac arrest. Unconscious and breathing: recovery position. Not breathing: CPR. The adult dose, for over fifty kilograms, is the three-tenths of a milligram auto-injector. Remove it from the case, remove the blue safety cap, orange tip down, put it at a right angle to the middle of the outer thigh, press firmly until it clicks, hold ten seconds. Through clothing is fine. Massage the spot for ten seconds, hand the used pen to the paramedics or put it in a sharps container. Outer thigh muscle only, never a vein. After five minutes, reassess. Not better, and there's a second auto-injector: give a second dose. No

D

Dorothy (continued)

pen: keep up airway, positioning and monitoring, and tell the dispatcher. No food or drink, and don't leave them alone.



Herman

Last in this group, drowning, and the first lesson is not to be a hero. Untrained rescuers frequently become drowning victims. Unless you are a trained swimmer or lifeguard, don't enter the water. Use a pole, a rope, a flotation device, throw something buoyant, or call a trained rescuer.



Corn

And the thing the film version gets wrong with the water in the lungs?



Hilbert

That one. Don't try to get water out of the lungs. MDA states it's impossible, dangerous, and wastes critical time. No Heimlich, no turning them upside down. And a rescued person goes to hospital even if they look fine, because blood-salt changes can be dangerous, and delayed lung swelling can show up one to twenty-four hours later. They shouldn't be allowed to refuse transport.



Corn

Fully recovered and still on the way to the ambulance. Nobody will enjoy that argument.



Herman

Probably not. Dorothy, the steps, please.

D

Dorothy

Check your own safety, and call one-oh-one before or during the rescue, even before if you're alone, on speaker, with your exact location: beach name, pool address, coordinates if you can. Send someone for an AED, often at lifeguard stations. Get the person out and onto a dry area away from the edge, without endangering yourself. Check response and

D

Dorothy (continued)

breathing. Responsive and breathing normally: recovery position, remove wet clothing if possible, dry blankets, watch breathing. Otherwise, on their back on a firm, dry, flat surface, CPR. Drowning is an oxygen-deprivation emergency, so the sequence differs. If you're trained: airway, two breaths, then compressions, thirty to two, at a rate of one hundred a minute. If not, hands-only at one hundred a minute, and the guidance suggests the tempo of Stayin' Alive by the Bee Gees. With an AED, dry the chest thoroughly and be on a dry surface before applying pads. Don't stop until they breathe on their own or paramedics take over. Then hospital, however they look.



Corn

Group two. Bleeding and trauma. Nine protocols, starting with severe bleeding. The idea is escalation. You start with the simplest thing and move up only if it fails. Direct pressure first, then the Israeli bandage, then, depending on where the wound is, either packing or a tourniquet. The common mistakes: lifting the dressing to peek, pulling out whatever is stuck in the wound, and assuming a racing pulse is only nerves. A rapid pulse should make you suspect blood loss.



Hilbert

Peeking is a hard habit to break. You want to know if it worked.



Corn

And every peek tears the clot. If a dressing soaks through, add layers on top, never remove the first. Call one-oh-one immediately, though if you're alone and the bleeding is immediately life-threatening, control it first and call as soon as possible. Dorothy, over to you.

D

Dorothy

Gloves if you have them, scene safe. An embedded object, a knife, shrapnel, glass? Don't remove it. Pad and bandage around it, press around it, not on it. Otherwise press strongly and directly with a gloved hand or sterile gauze, without lifting. If you can, elevate the limb above heart level, as an add-on, not a replacement. Not controlled: the Israeli Emergency Bandage. White sterile pad on the wound, wrap the elastic through the pressure bar, reverse direction and keep wrapping, lock the closure bar. Still bleeding? On an arm or leg, tourniquet. In a junctional area, which is groin, neck, armpit or shoulder, pack the wound: gauze in finger by finger, filling it in a sunburst pattern to press the vessel from inside, then the attached dressing with direct pressure for one to two minutes, and tighten the straps. No packing for penetrating stab wounds, and don't widen the wound. A tourniquet goes five to ten centimetres above the bleeding, toward the heart, never over a

D

Dorothy (continued)

joint. Tighten the windlass until the bleeding stops, secure it, and write TQ and the time in four digits, say TQ fourteen thirty, on the forehead or somewhere visible. Then watch for shock: fast pulse, pale, cool, clammy skin, confusion, fast breathing. Lying down, warm, legs raised if no spinal injury, nothing to eat or drink, and update the dispatcher if they worsen.



Corn

Next, the tourniquet.



Herman

It's the thing people hesitate over. MDA teaches a progression: direct pressure, Israeli bandage, wound packing, pressure points, then tourniquet. But there are cases where you skip straight to it. Amputation or a severe crush injury, bleeding from a limb that pressure can't control, a multi-casualty scene where you can't hold pressure on everyone, or when the environment is too dangerous to stay put.



Corn

And the fear is the limb.



Hilbert

The protocol answers that directly: do not delay a tourniquet in life-threatening bleeding out of fear of limb loss. Losing a limb is preferable to losing a life. The rest of the don'ts: never remove it once it's on, only medical professionals decide that. Don't loosen it to check whether the bleeding stopped, because that can restart the hemorrhage. Don't try to convert it to a pressure dressing, that's a professional decision. Don't let the casualty walk or move the limb. And never on the groin, armpit, neck, head or abdomen. Those get pressure, packing, or pressure points. Over to Dorothy for the run-through.

D

Dorothy

Expose the wound by cutting or removing clothing. Place the tourniquet between the wound and the heart, over a single bone if possible, upper arm or upper thigh. Pull the strap tight and fasten it. With a CAT or similar commercial one, twist the windlass rod until the bleeding stops completely, then lock the rod in its clip. If you're improvising, a shirt, towel or belt, tighten as hard as you can until the bleeding stops. That's less reliable,

D

Dorothy (continued)

but it can work as a last resort. Check the bleeding has really stopped. If not, put a second tourniquet above the first, tighten, and check again. Write the time on the white tab, the skin, anywhere obvious, because the hospital needs it to judge whether the limb can be saved. Call one-oh-one, and say a tourniquet is on, with the location, the injury, and the time. Then monitor for shock, keep them calm, still and warm, and don't let them walk. If they become unconscious but breathing, recovery position. If breathing stops, CPR.



Hilbert

Shock. The word that gets used for everything except shock. Signs: fast weak pulse, pale, cold, clammy skin, rapid shallow breathing, confusion, dizziness, nausea, thirst. Causes range from blood loss and spinal injury to heart failure, infection and allergic reaction. You call one-oh-one, check airway and breathing, stop any bleeding, and position them.



Herman

The legs thing, though. I'd have done that wrong.



Hilbert

There's a fork, so listen. Dorothy, walk us through it.

D

Dorothy

If they're conscious, lay them on their back and raise the legs about thirty centimetres, twelve inches, above heart level. Do not raise them if there's a suspected head, neck or spinal injury, a broken hip or leg, if it hurts, or if breathing is difficult. If they have trouble breathing, keep them semi-upright instead. Spinal or fracture, keep them flat and move them as little as possible. Don't give food or drink, and if they're thirsty, moisten the lips only. Keep them warm with a blanket or coat, insulation under them against cold ground, because shock patients lose heat even in hot weather. But don't overheat them. If it looks like anaphylactic shock and they have a prescribed EpiPen, help them use it. If they vomit and no spinal injury is suspected, turn them on their side. Unconscious but breathing, recovery position. Not breathing, CPR. And when the crew comes, give them the time of injury or onset, every treatment given, tourniquet time, and any changes.



Herman

Head and spinal injury. The long one. It has the longest list, so here's the core. If you suspect a head or spinal injury, you do not move the person. Moving is only for immediate danger to life: fire, an active threat, a collapsing structure. Don't twist, flex or extend the neck, don't sit them up, don't pull them by the arms or legs, and don't give food or drink, even if they're dehydrated, because of the risk of vomiting and aspiration. And the lesson that surprises people: don't use head-tilt chin-lift on an unconscious person. It moves the neck. Use the jaw thrust. Call one-oh-one for any suspected head or spinal injury, always, including momentary loss of consciousness, confusion after a blow, neck or back pain after trauma, numbness or weakness in a limb, blood or clear fluid from the nose or ears, unequal pupils, or seizures. Leave a motorcycle or bicycle helmet on unless the person cannot breathe. Open the face shield for communication and airway checks. Removal needs two trained people, one holding the neck still. Dorothy, read us the steps.

D

Dorothy

Is the scene safe? If there's immediate danger to life, move them only as a last resort, with a log-roll. Otherwise don't. Call one-oh-one with the exact location and how it happened. An isolated stab or gunshot wound with no blunt trauma and no neurological problems doesn't need spinal immobilisation: manage the wounds, still call. Anything else, assume spinal injury and start manual in-line stabilisation, the single most important intervention. Kneel or lie behind the head, hands on both sides, cupping the ears gently, head neutral and in line with the body. Hold it until professionals arrive and keep talking to them. If they resist or it hurts when you try to straighten the head, hold it as found. Unconscious: jaw thrust, fingers behind the angles of the jaw on both sides, push the jaw forward without moving the neck. Check breathing and pulse. If neither, CPR with spinal precautions: jaw thrust for breaths, ideally with two responders, normal compressions, severe bleeding controlled first. Scalp bleeding: gentle pressure with a clean dressing. Suspected skull fracture, with depressed bone, deformity or brain matter: no pressure, cover loosely with a sterile dressing. Don't plug ears or nose if blood or clear fluid drains. Don't pull them out of a vehicle unless it's on fire or there's another immediate threat. Check sensation in all four limbs, fingers and toes moving, left against right, pupils. A cervical collar only if you have one, correctly sized, with a second person holding the head. Keep them warm, shaded in the sun, and watch for lower alertness, repeated vomiting, seizures, unequal pupils, one-sided weakness. Concussion shows as headache, fogginess, dizziness, nausea, and you don't need to lose consciousness for it. Rolling takes at least three people, the person at the head commanding, as a single unit.



Hilbert

Fractures and sprains. Back to ground level. The big lesson: never try to straighten or realign a broken limb, because that can tear arteries and nerves. And never push a protruding bone back in. If you can't tell whether it's a fracture or a sprain, treat it as a fracture.



Corn

Heroic instinct again. Fix the bone.



Herman

Call one-oh-one for a suspected fracture, an open fracture, head, neck, spine, pelvis or hip, numbness or lost circulation, signs of shock, or any doubt. A fracture means severe pain that worsens on movement, deformity, a limb that won't move, rapid swelling. A sprain is joint pain, swelling and bruising, no deformity. Dorothy, you have the floor.

D

Dorothy

Open fracture, bone through the skin: press around the bone, not on it, with a tourniquet if it's severe. Cover with a sterile dressing or clean cloth, support the limb as found, no realigning, watch for shock. Closed fracture: most comfortable position, don't move it. For an arm, support it with the healthy hand and use a sling, a shirt, scarf or triangular bandage, tied at the neck and attached to the chest. For a leg, pillows or rolled blankets on both sides. For thigh and below, tie a triangular cloth firmly above the injury, knot on the uninjured leg. Ice wrapped in cloth, never on bare skin, in fifteen-minute intervals. Rings, bracelets and watches off at once, before the swelling. No walking on a suspected leg fracture, no heat. A sprain gets RICE. Rest, no weight. Ice in cloth for fifteen to twenty minutes every two to three hours, for the first forty-eight to seventy-two hours. Compression with an elastic bandage, firm but not tight, loosened at once if fingers or toes go numb, pale or blue. Elevation above the heart. Call or go to the emergency department if they can't bear weight, there's deformity, unrelenting pain, numbness, or extreme swelling that RICE doesn't help. Otherwise, no improvement in forty-eight to seventy-two hours means get it checked.



Herman

Burns. I have a feeling about butter. And the guidance does too. Don't apply toothpaste, ground coffee, raw egg, yogurt, butter or any home remedy, because they trap heat and raise infection risk. No fat-based creams on a fresh burn either. And no ice or ice-cold water, since extreme cold causes additional damage.



Corn

My feeling was correct, then.



Hilbert

It was. The right treatment is cool, not cold, running water for at least ten minutes. And don't pop the blisters, because the fluid protects the tissue. Dorothy, take us through it.

D

Dorothy

Safe scene, remove them from the heat source. Degrees: first is red, slightly swollen, painful, no blisters. Second is severe pain, redness, fluid-filled blisters. Third is brown-white, grey, yellowish or black tissue, stiff and dry, with little or no pain because the nerves are destroyed. Call one-oh-one for third-degree burns, anything larger than the palm of the casualty's hand, face, mouth, hands, feet, genitals or groin, chemical, electrical or inhalation burns, and high-risk people: pregnant women, the elderly, chemotherapy patients. Cool for at least ten minutes, ten to twenty or until the pain subsides. Take off rings, watches and loose clothing before swelling. Clothing stuck to the burn: cut around it, don't pull. Cover loosely with cling film, a clean plastic bag or a clean non-fluffy dressing. Lay them down and warm. Chemical: remove contaminated clothing, protecting yourself, rinse with a massive amount of cool water for at least fifteen to twenty minutes, eyes at least fifteen, no neutralising, and call one-oh-one. Electrical: confirm the power is off before approaching, call one-oh-one, be ready for CPR, and expect internal injury. For a mild first-degree burn, ibuprofen or paracetamol can ease pain. Watch for infection, breathing trouble and shock.



Corn

Eye injuries. Four situations, each with a different rule. Chemical splash, flush immediately. An embedded object, hands off. A foreign body such as dust or sand, don't rub. A cut to the eyeball, don't wash it.



Herman

Which is why "just rinse it" isn't enough. Dorothy, the steps, please.

D

Dorothy

Chemical splash: flush with a stream of running water for fifteen to thirty minutes, eyelid held open, head tilted so the water runs away from the good eye. Contact lenses out once the flush has started. Note the product name or bring the container. Then the emergency room, and one-oh-one for a severe burn or if they can't open the eye. Embedded object: don't remove it or press. Cover both eyes loosely to prevent sympathetic eye movement, with a cup, cone or ring of cloth around the object. Keep them calm and still, and call one-oh-one at once. Foreign body: don't rub. Rinse with lukewarm running water for about fifteen minutes, checking every five. If it stays, or pain, redness or tearing persist, emergency room. Blunt trauma: gentle cold compress, not on the eyeball. Vision affected,

D

Dorothy (continued)

double vision, blood in the eye, irregular pupil or severe pain: call one-oh-one. Even if it looks normal, get it checked. A cut to the eyeball or eyelid: no washing, cover loosely with a sterile pad, no pressure, call one-oh-one, keep them lying down. Sudden vision loss or blood in the eye also means one-oh-one.



Hilbert

Blast and shrapnel injuries. The first lesson is that your own safety comes first: don't approach until security forces confirm the area is safe, because secondary devices, a second bomb, are a known tactic.



Corn

Which makes sense of the "don't be a hero" theme running through half of these.



Herman

It does. The second lesson is that blast victims have injuries from several mechanisms at once, so look past the obvious wound. MDA's approach is scoop and run: immediate life-saving treatment only, then rapid evacuation. Dorothy, over to you.

D

Dorothy

Confirm the scene is safe, watching for secondary devices, collapse and fire. Call one-oh-one with location, number of casualties and that it's an explosion, so MDA can activate mass-casualty protocols. Scan for life-threatening bleeding first. Direct pressure, then an Israeli bandage, checking the pulse beyond it. Then packing for large wounds, then a tourniquet above the injury, tightened until the bleeding stops, with the time documented. With many casualties, the tourniquet comes earlier. Embedded shrapnel: don't move it, press either side, stabilise. Check the whole body for more wounds. Cool burns with clean water, leave stuck clothing, cover with a non-adherent dressing. Watch for shock, keep them still and warm, no walking. Airway with jaw thrust, not head tilt. Not breathing: CPR, thirty to two. The guidance also says no epinephrine in blood-loss trauma, which is a paramedic matter anyway.



Corn

Electrocution. Last in this group, and the rule is simple. Don't touch them. Contact with a victim who is still connected to the current can kill you too, and the guidance says multiple rescuers have died of chain electrocution. Power off first.



Herman

A lot of heroes in this group.



Hilbert

Which is why it keeps coming up. Low voltage is under one thousand volts, household and most workplaces. High voltage is one thousand and up: power lines, substations, industrial equipment. Over to Dorothy for the run-through.

D

Dorothy

High voltage: stay at least ten metres back and call one-oh-one, Fire at one-oh-two, and the Israel Electric Corporation at one-oh-three, and wait for them to de-energise it. Low voltage: switch off the mains breaker or unplug the appliance, and confirm it's off. If you can't, use a completely dry non-conducting object, a dry broom handle, rope, rubber mat or clothing, to push or pull them free, standing on dry insulation like dry wood, a rubber mat or a stack of newspapers. Never a wet object. Call one-oh-one with location, casualties, whether the power is off, and their condition. Once it's safe: unresponsive and breathing normally, recovery position. Not breathing or only gasping, CPR, thirty to two, and an AED on a dry chest. Burns: look for entry and exit wounds, which can look small while hiding severe damage along the path. Cool them for at least ten minutes once the scene is safe, cover loosely, no creams. Thrown or fell from a height: suspect spinal injury. Shock care: lying down, warm, nothing by mouth, legs slightly raised unless spinal injury or breathing difficulty. And every victim goes to hospital, because heart rhythm problems can appear hours later and muscle breakdown can cause kidney failure.



Herman

Group three. Medical. Five protocols, starting with seizures. Most of seizure first aid is restraint, yours. Protect the person, time it, and let it run. Don't hold them down, because you can't stop a seizure by force and restraining can cause fractures or dislocations. Nothing in the mouth, no spoons, wallets, fingers, because they cannot swallow their tongue and objects risk broken teeth and bite injuries. No water poured on them, no mouth-to-mouth during the seizure, since people usually resume breathing on their own once it ends.



Corn

So the entire job is standing guard. I could do that, and slowly.



Hilbert

Standing guard with a clock. Note the start time, since most seizures end within one to three minutes. Dorothy, walk us through it.

D

Dorothy

Clear sharp objects and furniture, guide them to the ground if they're upright, put something soft under the head, loosen ties, scarves, collars, belts. Vomiting or heavy saliva: turn them on their side, mouth pointing down. Ask bystanders to step back. Don't move them unless they're in danger, in a road, near a ledge, fire or water. Over five minutes, call one-oh-one at once. That's status epilepticus, a medical emergency. Also call for a second seizure without waking in between, a first-ever seizure, breathing difficulty afterwards, pregnancy or diabetes, or an injury. When it ends: recovery position, check breathing, and if they aren't breathing normally, call and start CPR. Speak calmly as they come round, since they'll be confused. Known epilepsy and a typical seizure under five minutes: stay until fully recovered and make sure someone accompanies them. Nothing by mouth until fully alert. Prescribed rescue medication is only for someone with a prescription and a trained caregiver, given as the neurologist instructed once a seizure passes three minutes. If it doesn't stop, call one-oh-one.



Corn

Diabetic emergencies. The sugar one. And the lesson is a default. When you can't tell whether blood sugar is high or low, give sugar. Giving sugar to someone who's low is life-saving, and giving it to someone who's high won't cause significant immediate extra harm.



Herman

A rule built for people who can't work it out under pressure. I like those.



Corn

Any unexplained altered consciousness, even in someone who isn't diabetic, is a reason to check blood sugar with a glucometer if one is there. The mistakes: diet drinks, which won't raise sugar, high-fat sweets like chocolate bars or ice cream, which slow absorption,



Corn (continued)

giving anything to an unconscious person, and never insulin as a first aider. Dorothy, read us the steps.

D

Dorothy

Look for a medical alert bracelet, card, pump, pens or glucometer. With a glucometer, below sixty to seventy milligrams per decilitre is low, above two hundred fifty is high. Low, and conscious and able to swallow: sweetened juice or a sugary soft drink, not diet, sugar cubes, glucose tablets, a glucogel packet of fifteen grams, or honey or jam. Then a complex carbohydrate like bread or crackers. Don't leave them alone. No improvement in ten to fifteen minutes: call one-oh-one, since they may need intravenous dextrose. Drowsy but not unconscious: honey or chocolate spread under the tongue or inside the cheek, if safe, and call one-oh-one. Unconscious: recovery position, call one-oh-one, glucagon only if they have a kit and you're trained, disconnect an insulin pump gently, and be ready for CPR. High sugar, gradual over hours or days, with thirst, frequent urination, fruity breath, fast deep breathing, warm dry skin: call one-oh-one if ketoacidosis is suspected, open the airway, loosen clothing, and give small sips of water if conscious. Unconscious, nothing by mouth. Call one-oh-one also for seizures, or if you're unsure which type it is.



Hilbert

Poisoning, where the internet has strong opinions, mostly wrong ones. No inducing vomiting, unless the Poison Information Center or a physician directs it. No salt water, mustard, raw eggs or other home remedies. No trying to neutralise a poison, acid for a base or the reverse. No activated charcoal without medical direction, and no antidotes, those are hospital-level. Don't give food or drink unless directed.



Corn

Mustard and raw eggs sound like the plot of a very bad cooking show.



Herman

Keep the Rambam number handy: zero four, seven seven seven, one nine zero zero. Dorothy, you have the floor.

D

Dorothy

Make the scene safe. For fumes, don't enter a confined space without protection. Call one-oh-one for serious poisoning, unconsciousness, breathing difficulty, seizures, caustic or unknown substances, large amounts, intentional overdose, or carbon monoxide, and call the Poison Center for substance-specific guidance. Have the substance, amount, time, and the person's age and weight ready. Keep containers, packaging, pills, even a vomit sample. Swallowed caustic or corrosive, acids, bases, strong detergents: never induce vomiting, and if they're conscious and breathing normally give about one cup, two hundred fifty millilitres, of water or milk. Other swallowed poison: no vomiting unless directed, remove poison remaining in the mouth carefully. Inhaled: fresh air at once, without entering a toxic area yourself, and call one-oh-one. Skin: remove contaminated clothing, protecting yourself, flush with lots of cool water for at least fifteen to twenty minutes. Eyes: at least fifteen, lids held open. Conscious: calm, warm, never alone. Unconscious and breathing: recovery position. Not breathing: CPR.



Hilbert

Smoke and tear gas. The lesson for smoke is that someone who looks stable isn't. Symptoms can worsen over hours as the airway swells. Soot around the mouth or nose, or singed facial hair, signal potentially serious airway injury needing hospital evaluation. And don't re-enter a smoke-filled building unless you're a firefighter with breathing apparatus.



Corn

Same hero problem again.



Herman

Everywhere. Dorothy, take us through it.

D

Dorothy

Smoke. Stay low where the air is cleaner, since smoke rises. If you can safely move them, get them to fresh air. If not, wait for Fire and Rescue, one-oh-two, or MDA. Call one-oh-one, and one-oh-two if the fire is ongoing. Conscious: sit them upright. Unconscious but breathing: recovery position. Not breathing: CPR, thirty to two. Cool burns with clean water, leave stuck clothing, cover with a non-adherent dressing, and keep them warm, since they can become hypothermic. Tear gas: move away from the source to fresh air, upwind if possible. Flush the eyes with clean, tepid water or saline for at least fifteen minutes, and don't rub them, nor use milk. Remove contaminated clothing, wash the skin with soap and water, blow the nose. Symptoms should ease once the exposure ends. If not better, or worse after thirty minutes in fresh air, call one-oh-one. Those with asthma or COPD, children, the elderly and pregnant people should get medical attention

D

Dorothy (continued)

regardless.



Herman

Dehydration, and then heat in the next group. The overlap's confusing. The key distinction: dehydration means you're still sweating. Heat stroke means sweating has stopped, with a body temperature above forty degrees Celsius, hot, dry, red skin, and confusion. Everything else follows from which one you're in front of.



Corn

Is that a trap? Sweating less sounds like improvement.



Hilbert

It's the reverse, and the guidance flags it. Dehydration signs: thirst, dry mouth, dark or reduced urine, fatigue, dizziness, headache, fast pulse. Dorothy, the steps, please.

D

Dorothy

Heat stroke: call one-oh-one at once. Otherwise: stop activity, move them to shade or an air-conditioned room, loosen and remove excess clothing, and rehydrate with small sips of water or oral rehydration solution, which is better than plain water for moderate dehydration. At home: one litre of clean water, six teaspoons of sugar, half a teaspoon of salt. Cool them with wet cloths, a fan or a cool water spray. Not large quantities fast, which disrupts electrolyte balance. No sugary drinks, coffee or alcohol. If not better after thirty minutes, vomiting stops them drinking, or shock signs appear, call one-oh-one. Heat stroke: shade or air conditioning, cool rapidly with ice, wet towels, fans and cold water on the torso, continuously until MDA arrives. Conscious: small sips of water only. Unconscious: lay them on their back with legs raised, recovery position if breathing, and no fluids. Don't wet the head of a heat stroke patient, because of choking risk if consciousness is altered.



Corn

Group four. Environment. Two protocols. Heatstroke and heat exhaustion first. This one splits in two, and which side you're on decides everything. Heat exhaustion: heavy sweating, warm moist skin, dizziness, nausea, headache, weakness, muscle cramps, fast pulse. Heat stroke: above forty degrees Celsius, hot dry skin, though sweating may have



Corn (continued)

stopped, confusion, staggering, hallucinations, seizures, loss of consciousness. The don'ts include something people do by reflex: no fever-reducing medicine, paracetamol or ibuprofen, because antipyretics don't work for environmental overheating and may do harm.



Hilbert

Then no Acamol for a sunburnt hiker.



Corn

Not for this. Dorothy, over to you.

D

Dorothy

Heat stroke: call one-oh-one now, move to shade or air conditioning, remove unnecessary clothing, and cool aggressively. Wet towels on the neck, armpits and groin, where major vessels run close to the skin, cool water on the body, fan vigorously, cold packs at neck, armpits and groin. Fully conscious and able to swallow: small sips of cool water continuously. Otherwise no fluids, recovery position if breathing. Raise the legs if blood pressure drops. Unresponsive and not breathing: CPR. Heat exhaustion: shade or air conditioning, lie down, legs slightly raised if blood pressure seems low, loosen clothing, wet towels, spray, fan. Sips of cool water if fully conscious and able to swallow. If not, call one-oh-one. If it isn't improving, call one-oh-one, since it may be turning into heat stroke. And never leave them alone.



Herman

Hypothermia. The opposite problem. And the counterintuitive part is that you warm the middle first. Torso first, not the hands and feet. Warming the extremities first can send cold blood rushing to the heart and trigger cardiac arrest, which is called afterdrop. For the same reason, no rubbing the extremities, no hot baths, no heating pads on bare skin, no vigorous rewarming. Rapid rewarming can cause dangerous heart rhythm problems.



Corn

The instinct is to rub their hands and give them a brandy.



Hilbert

And alcohol is out. It dilates blood vessels and speeds heat loss. Caffeine too. Hypothermia means body temperature below thirty-five degrees Celsius: shivering, confusion, pale cold skin, slurred speech, stiffness. Over to Dorothy for the run-through.

D

Dorothy

Call one-oh-one first. Warm dry shelter, out of wind and rain. Wet clothes off, dry layers on. Blankets including the head. Indoors, warm the room to about twenty-two degrees. Conscious and able to swallow: warm, not hot, drinks. Otherwise nothing by mouth, and be ready for CPR. Heat packs on chest, abdomen and back only, with a cloth barrier. Monitor breathing continuously, and if it stops, CPR. Keep gently rewarming until the ambulance comes.



Hilbert

Group five. Bites and stings. Three protocols, and they share a lot. The shared lessons: stay calm and keep the victim calm and still, because stress and a fast heart rate speed up venom spread. Remove rings, watches and tight clothing, since the area swells. And never a tourniquet, never cutting, never sucking. They trap venom locally and cause tissue damage. Start with snakes. Call one-oh-one. Dispatch gives guidance until paramedics arrive, and you can call the Poison Center for toxicology advice.



Herman

So no cutting and sucking, like the cartoons.



Corn

That one's dangerous and ineffective. Also no ice or cooling, no food or drink, no inducing vomiting, no aspirin, ibuprofen or naproxen, since viper venom is often anticoagulant, and no alcohol-based disinfectants. Dorothy, walk us through it.

D

Dorothy

Lie them down, completely still. Bitten limb below heart level and splinted against the body. Wash the bite gently with soap and water only. Photograph the snake from at least two metres if safe, or note colour, pattern, size, head shape. Don't try to catch or kill it, since snakes are protected under Israeli law and it risks more bites. Watch for difficulty breathing or swallowing, spreading swelling, rash, abdominal pain, vomiting, changes in

D

Dorothy (continued)

consciousness, falling blood pressure, fast heart rate. Severe signs: report to dispatch, be ready for CPR, legs raised if blood pressure drops. They must go to hospital for evaluation and possible antivenom. In Israel antivenom exists for Daboia palaestinae and Echis coloratus bites. There is no antivenom for the Israeli mole viper, Atractaspis engaddensis. Remote location and a long wait: if safe transport exists, move them while keeping them still, limb below heart level, in phone contact with MDA.



Hilbert

Scorpions. The lesson is that local pain doesn't predict systemic danger. And a common belief is false: that black scorpions aren't dangerous. Several black species are medically significant. The deathstalker, Leiurus quinquestriatus, is yellow and the most dangerous in Israel. Every sting needs hospital evaluation, with observation for a minimum of six hours from the time of the sting.



Corn

Six hours in the waiting room. For something the size of a thumb.



Herman

Dorothy, read us the steps.

D

Dorothy

Call one-oh-one straight away, and don't wait for symptoms. Keep them calm, lying down, as still as possible. Stung limb at or below heart level, which differs from the spider advice. Remove jewellery and tight clothing. Watch for restlessness, confusion, difficulty breathing or swallowing, heavy sweating, salivation, tearing, rapid or irregular heartbeat, seizures, twitching, vomiting, blood pressure changes. Any of those: tell dispatch, it's a severe envenomation, keep the airway open, CPR if they stop breathing. Photograph the scorpion or note colour and size, only if safe. Scorpion antivenom is available in Israeli hospitals and may be given in rare severe cases. The don'ts: no tourniquet, no sucking, no cutting, no food or drink, no walking. And no ice. Israeli Ministry of Health guidance advises against cooling, and if dispatch does tell you to cool, use ice wrapped in cloth, briefly. Remote location: if safe transport exists, move them, limb at or below heart level, in phone contact with MDA.



Corn

Spiders. Last protocol of the lot. And the first lesson is a relief: most spider bites in Israel aren't life-threatening. The second is that most "spider bites" aren't spider bites. About eighty-three and a half percent of cases presenting as spider bites turned out to be other conditions, bacterial infections, allergic reactions, other arthropod bites. Don't assume it's a spider without confirmation.



Hilbert

A lot of blame going to eight-legged suspects.



Corn

Two species matter in Israel. The Mediterranean recluse, the small brown violin spider, and its bite is often painless at first, then burns, blisters, and develops a blue, white and red pattern, with tissue death over hours to days. So don't ignore mild early symptoms. And the Mediterranean black widow, dark with markings, less common, more dangerous systemically: pain starting between fifteen minutes and an hour, two fang marks, spreading pain, muscle cramps especially in the abdomen, sweating. Dorothy, you have the floor.

D

Dorothy

Move away, stay calm, don't risk another bite catching it, photograph if safe. Wash with mild soap and water. Cool compress, a damp cloth or wrapped ice pack, fifteen minutes each hour, never ice on bare skin. Bitten area elevated and still, which differs from snakes and scorpions. Suspected black widow, severe pain, cramps, difficulty breathing, nausea, vomiting, fever, spreading redness or discolouration, any systemic symptom: call one-oh-one and the Poison Center. Black widow bites need hospital evaluation, possible antivenom, and watching the breathing. Recluse suspected: call the Poison Center and get medical attention without waiting for it to worsen. Call one-oh-one also if the victim is a child, elderly, or has existing conditions. Don't cut out a recluse bite, since early surgical excision worsens outcomes. No tourniquet, no cutting or sucking, no heat. Unconscious but breathing, recovery position. Not breathing, CPR.



Herman

That's all twenty-eight. If you only hold on to a handful, make it these.



Corn

Call one-oh-one early, and keep the phone on speaker. Someone who is unresponsive and not breathing normally, gasping included, gets CPR: hard and fast, one hundred to one hundred twenty a minute, five to six centimetres deep, and an AED the moment one arrives. It cannot harm someone who doesn't need a shock.



Hilbert

Severe bleeding gets firm direct pressure, no peeking, and on a limb that won't stop, a tourniquet that stays on until professionals take it off. An unconscious person who is breathing goes on their side. And a suspected spinal injury stays exactly where it is unless there's immediate danger.



Corn

Chewed aspirin for a heart attack, nothing by mouth for a stroke, epinephrine without delay for anaphylaxis. Cool, not cold, running water for burns. And a snake, scorpion or spider bite means calm, still, and an ambulance, with no tourniquet, no cutting, no sucking.



Herman

Then come back. Daniel's point was that this should be re-listened to every few months, because details fade.



Hilbert

The material comes from Daniel's free, open-source Family First Aid app for Android, which is on GitHub. The children and infants edition has its own episode. One more time: in an emergency, one-oh-one.



Herman

Thanks to Dorothy for reading the protocols, and to Hilbert Flumingtop for producing. This has been My Weird Prompts.



Corn

Find us at my weird prompts dot com. See you soon.