   a. Support the infant's head as needed and apply gentle counterpressure to help prevent the head from suddenly popping out
3. Check for nuchal cord (i.e., around the baby's neck)
   a. If present, slip it over the head
   b. If unable to free the cord from the neck, double clamp the cord and cut between the clamps
4. Do **not** routinely suction the infant's airway (even with a bulb syringe) during delivery
5. Grasping the head with hand over the ears, gently guide head down to allow delivery of the anterior shoulder
6. Gently guide the head up to allow delivery of the posterior shoulder
7. Slowly deliver the remainder of the infant
8. After 1 minute, clamp cord about 5–6 inches from the abdomen with two clamps; cut the cord between the clamps
   a. If resuscitation is needed, the baby can still benefit from a 1-minute delay in cord clamping. Start resuscitation immediately after birth and then clamp and cut the cord at 1 minute
   b. While cord is attached, take care to ensure the baby is not significantly higher positioned than the mother to prevent blood from flowing backwards from baby to placenta
9. Dry, warm, and stimulate infant, wrap in towel and place on maternal chest unless resuscitation needed
10. Resuscitation takes priority over recording APGAR scores. Record APGAR scores at 1 and 5 minutes once neonate is stabilized
11. After delivery of infant, suctioning (including suctioning with a bulb syringe) should be reserved for infants who have obvious obstruction to the airway or require positive pressure ventilation (follow Neonatal Resuscitation Guideline for further care of the infant) The placenta will deliver spontaneously, often within 5–15 minutes after the infant is delivered
    a. Do not force the placenta to deliver; do not pull on the umbilical cord
    b. Contain all tissue in plastic bag and transport
12. After delivery, massaging the uterus (should be located at about the umbilicus) and allowing the infant to nurse will promote uterine contraction and help control bleeding
    a. Estimate maternal blood loss
    b. Treat mother for hypovolemia as needed
13. Transport infant secured to mother with approved neonatal restraint system, in car seat or isolette unless resuscitation is needed
14. Keep infant warm during transport
15. Most deliveries proceed without complications – If complications of delivery occur, apply high flow oxygen to mother and expedite transport to the appropriate receiving facility. Maternal resuscitation is critical for best fetal outcome. Contact medical direction and/or closest appropriate receiving facility for direct medical oversight and to prepare the receiving team. The following are recommendations for specific complications:
    a. Shoulder dystocia – if delivery fails to progress after head delivers, quickly attempt the following
        i. Hyperflex mother's hips to severe supine knee-chest position (i.e., McRoberts' maneuver)
        ii. Apply firm suprapubic pressure to attempt to dislodge shoulder. This often requires two EMS clinicians to perform and allows for delivery in up to 75% of cases
        iii. Attempt to angle baby's head as posteriorly as possible but NEVER pull