Date: [Insert Date]

RE: Emergency Seizure Medication Protocol

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Diagnosis: [Insert Diagnosis/Seizure Type]

To Whom It May Concern,

This letter serves as the official medical protocol for managing seizures for the above-named patient. In the event of a seizure emergency, please follow the instructions below.

Emergency Medication Details:

- **Medication Name:** [Insert Name, e.g., Midazolam/Diastat]
- **Dosage:** [Insert Dose, e.g., 5mg]
- **Route:** [Insert Route, e.g., Intranasal/Rectal/Buccal]

Administration Criteria:
Administer the emergency medication if:

- The seizure lasts longer than [Insert Number] minutes.
- The patient has [Insert Number] or more seizures within a [Insert Number] hour period.
- [Insert Other Specific Clinical Triggers].

Emergency Procedures:

1. Clear the area of sharp objects and cushion the head.
2. Time the seizure.
3. Administer medication as prescribed above.
4. **Call 911 if:**
    - The seizure continues [Insert Number] minutes after medication is given.
    - The patient has difficulty breathing.
    - This is the patient's first known seizure.
    - The patient is injured.

Physician Contact Information:
Physician Name: [Insert Physician Name]
Office Phone: [Insert Phone Number]
After Hours Phone: [Insert Phone Number]

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Clinic/Hospital Name]