Date: [Insert Date]

To: [Recipient Name/School Name/Facility Name]
From: [Physician Name/Parent/Guardian Name]
Subject: Emergency Medication Protocol for [Patient/Student Name]

Patient Information:
Name: [Full Name]
Date of Birth: [DOB]
Diagnosis/Medical Condition: [Condition, e.g., Severe Allergy, Epilepsy]

Emergency Medication Details:
Medication Name: [Drug Name]
Dosage: [e.g., 0.3mg]
Route: [e.g., Intramuscular injection, Oral, Inhaler]

Administration Criteria:
Administer this medication immediately if the following symptoms occur:
[Symptom 1]
[Symptom 2]
[Symptom 3]

Step-by-Step Instructions:
1. [Step 1]
2. [Step 2]
3. [Step 3]

Post-Administration Procedure:
- Call 911/Emergency Services immediately after administration: [Yes/No]
- Notify emergency contact: [Name] at [Phone Number]
- Side effects to monitor: [List side effects]

Physician Authorization:
Physician Name: [Name]
Clinic Name: [Name]
Phone Number: [Number]
Signature: ___________________________

Parent/Guardian Consent:
I authorize the designated staff to administer the medication listed above according to the protocol provided.
Signature: ___________________________
Date: [Date]