EMT Medications — National Registry Quick Reference

Doses per AHA 2025 · scope per National EMS Scope of Practice Model 2019 + Change Notice 1.0 — Munden Interactive · emsnotes.com

Administer vs assist. Administer = giving a drug EMS stocks and carries. **Assist** = helping a patient take a drug they already own and are prescribed. **National EMT floor:** assist the patient's own prescribed meds; administer only physician-approved OTC — **oral glucose** and **aspirin**. Naloxone, epi auto-injectors and nebulized albuterol come to EMTs by **state protocol**. **AEMT adds:** SL nitro, IM/SQ epi for anaphylaxis, inhaled beta agonist, narcotic antagonist, glucagon, D50, IN/neb routes, nitrous oxide.

WHAT THE EMT ADMINISTERS OR ASSISTS

Medication	Dose	Route	Indication & the point that gets tested
Oxygen	**Titrate SpO_2 94–99%**	NC 1–6 L/min NRB 10–15	Not routine high-flow in ACS, stroke or post-ROSC. BVM for inadequate ventilation — no device substitutes for ventilation.
Oral glucose	**15 g**	PO (buccal)	BG < 70 with AMS. Repeat once in ~15 min. **Nothing by mouth** if unresponsive, seizing, or no gag reflex.
Aspirin	**162–325 mg chewed**	PO	Chest pain of suspected ischemic origin. Not for aspirin allergy or active bleeding. Antiplatelet — does not relieve pain.
Nitroglycerin *(assist)*	**0.4 mg q5 min ×3**	SL	Patient's own Rx only. **Do not** if SBP < 100, inferior/RV MI, or PDE5 inhibitor — sildenafil/vardenafil 24 h, tadalafil 48 h.
Albuterol (MDI, assist)	**2 puffs (~90 mcg ea)**	Inhaled	Wheezing/dyspnea. Silent chest + tiring = needs ALS, not just a neb. Expect tremor, tachycardia.
Albuterol (nebulized)	**2.5 mg / 3 mL**	Neb, O_2-driven	Repeatable. Inhaled epinephrine is **not** IM epinephrine.
Ipratropium	**0.5 mg**	Neb	Anticholinergic; often combined with albuterol as one unit dose (DuoNeb).
Epinephrine (auto-injector)	**0.3 mg adult** **0.15 mg <30 kg**	IM, anterolateral thigh	Anaphylaxis — first line, no substitute. Repeat 5–15 min. Do not delay for antihistamines or steroids.
Naloxone	**2–4 mg IN** **0.4 mg IM**	IN / IM	Titrate to **breathing**, not consciousness. Ventilate first. May re-sedate — transport. Harmless if not opioid.

KNOW IT, DON'T PUSH IT — THE BLS PARTNER'S LIST

Situation	Drug & dose	Why you need to know
Cardiac arrest	**Epi 1 mg (0.1 mg/mL) q3–5 min IV/IO**	Every 3–5 min, all rhythms. Two concentrations exist — never confuse them.
Refractory VF/pVT	**Amiodarone 300 mg, then 150** **Lidocaine 1–1.5 mg/kg, then 0.5–0.75 (max 3)**	Given after defibrillation attempts and epi.
Symptomatic bradycardia	**Atropine 1 mg q3–5 min (max 3 mg)**	Then pacing or a catecholamine infusion.
Stable narrow-complex tachy	**Adenosine 6 mg, then 12 mg**	Rapid push — expect a brief pause.
Hypoglycemia	**D50 25 g IV · Glucagon 1 mg IM**	Glucagon when there is no IV access. Pediatric dextrose is more dilute.
Pain / sedation (ALS)	**Fentanyl · morphine · midazolam · ketamine**	Monitor airway and respirations.

The six traps: (1) assist vs administer · (2) scope level — SL nitro, IM epi and beta agonists are AEMT nationally · (3) epi concentration 1 mg/mL vs 0.1 mg/mL · (4) withholding naloxone because the patient isn't "obviously" opioid · (5) nitro without asking about ED drugs or rechecking BP · (6) oral glucose to a patient who cannot swallow.
Five rights + two: right patient, drug, dose, route, time — plus *documentation* and the patient's *right to refuse*.