



Medication	Dose / Re-administration	Onset	Max Daily Dose (MDD) [‡] All routes	Peak Effect	Redosing Frequency ^Δ	Notes/monitoring
Diphenhydramine (antihistamine)	PO/IV/IM: 12.5 - 50mg (1 mg/kg/dose)	PO: 15 - 60 min IV/IM: 15 min	Child: 50 - 100 mg Adolescent: 100 - 200 mg	PO: 2 hours	Q 4 - 6 hours	Avoid in delirium. Can cause disinhibition or delirium in younger or DD youth. May cause QT prolongation.
Lorazepam (benzodiazepine)	PO/IV/IM/NGT: 0.5 mg - 2 mg (0.05 - 0.1 mg/kg/dose)	PO 20 - 30 min IV 2 - 5 min IM 15 - 30 min	Child: 4 mg Adolescent: 6 - 8 mg Depending on weight/prior medication exposure [#]	IV: 10 minutes PO/IM: 1 - 2 hours	Q 1 - 2 hours	Can cause disinhibition or delirium in younger or DD youth. Can be given with haloperidol, chlorpromazine or risperidone. Do not give with olanzapine (especially IM due to risk of respiratory suppression).
Clonidine (alpha-2 agonist)	PO: 0.05 mg - 0.1 mg	No reliable data	27 - 40.5 kg: 0.2 mg/day 40.5 - 45 kg: 0.3 mg/day >45 kg: 0.4 mg/day	PO: 30-60 minutes	Q 8 hours	Monitor for hypotension and bradycardia. Avoid giving with BZD or atypical antipsychotic due to hypotension risk.
Chlorpromazine (antipsychotic)	PO: 12.5 - 50 mg (0.55 mg/kg/dose) IM: 0.28mg/kg (max 25mg)	30 - 60 min	Child <5 years: 40mg/day Child ≥5 years: 75mg/day IM Route	PO: 30-60 minutes IM: 15 minutes	Q 4 hours	Monitor for hypotension. Monitor for QT prolongation.
Haloperidol [▲] (antipsychotic)	PO/IM: 0.5 mg - 5 mg (0.055 mg/kg/dose)	30 - 60 min	15-40 kg: 6mg >40 kg: 15 mg Depending on prior antipsychotic exposure	PO: 2 hours IM: 20 minutes	Q 4 hours	Monitor for hypotension. Consider EKG or cardiac monitoring for QT prolongation, especially for IV administration. Note: Risk of extrapyramidal side effects (EPS) with MDD >3mg/day, with IV dosing having very high EPS risk. Consider pairing with diphenhydramine to reduce risk of EPS (if not concerned for QT prolongation)
Olanzapine (atypical antipsychotic)	ODT or IM: 2.5 - 10 mg	15 min	10 - 20 mg Depending on antipsychotic exposure	ODT: 5 hours (range 1-8 hours) IM: 15-45 minutes	Q 2 hours	Do not give with or within 1 hour of any BZD given risk for respiratory suppression.
Risperidone (atypical antipsychotic)	ODT: 0.25 - 1mg (0.005-0.01mg/kg/dose)	60 - 70 min	Child: 1 - 2 mg Adolescent: 2 - 3 mg Depending on antipsychotic exposure	ODT: 1 hour	Q 0.5 - 2 hours	Can cause akathisia (restlessness/agitation) in higher doses.
Quetiapine (atypical antipsychotic)	PO: 25 - 50 mg (1-1.5 mg/kg/dose or divided)	No reliable data	>10 years: 600 mg Depending on prior antipsychotic exposure	PO: 30 minutes-2 hours	Q 12 hours	More sedating at lower doses. Monitor for hypotension.

[‡] Higher daily doses should occur in conjunction with psychiatry recommendation/guidance.[#] Higher doses should be lead to a reassessment of current plan / different therapeutic options[▲] IV route should be avoided due to the risk of arrhythmias or sudden cardiac arrest^Δ Consult with pharmacy to determine if redosing sooner is needed as initial dose may not have been maximized.Initially developed by Gerson et al., (2023) and has been reconceptualized by Children's Mercy Kansas City. Gerson, R., Malas, N., Feuer, V., Silver, G. H., Prasad, R., & Mroczkowski, M. M. (2023). Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) in the Emergency Department: Consensus Statement of the American Association for Emergency Psychiatry. *Focus*, 27(1), 80-88.