DOCUMENTATION OF PHYSICIAN'S ORAL ORDER
FOR PRN (AS NEEDED) MEDICATION

NAME OF PARTICIPANT: ________________________________________________________________

NAME OF PARTICIPANT'S PHYSICIAN GIVING ORDER: _______________________________________

DATE OF ORDER: ________________________________________________________________________

NAME AND STRENGTH OF MEDICATION: _________________________________________________

PHYSICIAN'S INSTRUCTIONS:

1. SYMPTOMS THAT MIGHT INDICATE USE OF THE MEDICATION: ____________________________

2. MEDICATION DOSAGE: __________________________________________________________________

3. TIME FRAMES THE MEDICATION IS TO BE GIVEN IN A 24-HOUR PERIOD: _________________

4. DIRECTIONS IF SYMPTOMS PERSIST: ________________________________________________

5. ANY ADDITIONAL INSTRUCTIONS: _________________________________________________

NAME OF CENTER STAFF RECEIVING ORDER:

PRINT: ____________________________________________

SIGNATURE: ______________________________________

032-05-076 (4/01)