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: **_____**