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*:** ____