

NURSE DELEGATION: PRN MEDICATION

TO BE COMPLETED ONLY IF PRN MEDICATIONS ARE DELEGATED

1. CLIENT NAME		2. DATE OF BIRTH	3. ID/SETTING (OPTIONAL)
4. DATE ORDERED	5. NAME OF MEDICATION	6. DOSE/FREQUENCY/ROUTE	
7. NOT TO EXCEED	8. REASON FOR MEDICATION		
9. SYMPTOMS FOR ADMINISTRATION AND AMOUNT TO BE GIVEN			
10. NOTES			
11. RND SIGNATURE			12. DATE
4. DATE ORDERED	5. NAME OF MEDICATION	6. DOSE/FREQUENCY/ROUTE	
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7. NOT TO EXCEED	8. REASON FOR MEDICATION		
9. SYMPTOMS FOR ADMINISTRATION AND AMOUNT TO BE GIVEN			
10. NOTES			
11. RND SIGNATURE			12. DATE

To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078 Toll Free

COPIES IN CHART AND RND FILE

INSTRUCTIONS FOR COMPLETING NURSE DELEGATION: PRN MEDICATION

All fields are required unless indicated “OPTIONAL”.

1. Client Name: Enter ND client’s name (last name, first name).
2. Date of Birth: Enter ND client’s date of birth (month, day, year).
3. ID Setting: **OPTIONAL** – Enter client’s ID number as assigned by your business OR enter Settings “AFH”, “BH”, DDD Program, “In-home”.
4. Date Ordered: Enter the date PRN medication was ordered.
5. Name of Medication: Enter the name of the medication ordered.
6. Dose/Frequency/Route: Enter dose, frequency of medication to be given and enter route of medication.
Examples: PO, Supp, Topical, Drops, etc.
7. Not to Exceed: Enter maximum number of doses in a specified time period, if applicable.
8. Reason For Medication: Enter action or reason medication is given.
9. Symptoms for Administration And Amount To Be Given: Enter behavior/symptom client will display when this medication is needed. Enter the dose that should be given when this behavior/symptom is observed.
10. Notes: Enter any additional information regarding this administration of this medication.
11. & 12. RND Signature and Date: Sign and date your signature.

Repeat boxes 4 through 12 for each additional PRN medication ordered at this time.