

## Nurse Delegation: PRN Medication

TO BE COMPLETED ONLY IF PRN MEDICATIONS ARE DELEGATED

1. CLIENT NAME		2. DATE OF BIRTH	3. SETTING
<b>Order 1</b>			
4. DATE ORDERED	5. NAME OF MEDICATION	6. DOSE / FREQUENCY / ROUTE	7. ROUTE
8. NOT TO EXCEED	9. REASON FOR MEDICATION		
10. SYMPTOMS FOR ADMINISTRATION			
11. NOTES			
12. RND SIGNATURE			13. DATE
<b>Order 2</b>			
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
<b>Order 3</b>			
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

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

DISTRIBUTION: Copy in client chart and in 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”, “ALF”, 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. and 12. RND Signature and Date: Sign and date your signature.

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

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