

PRN /OTC - MEDICATION FORM

INDIVIDUAL'S NAME: _____ MONTH/YEAR: _____

MEDICATION NAME: _____

ALLERGIES (food, drug, other): _____

PHYSICIAN: _____ ROUTE CODE: _____

MEDICATION INSTRUCTIONS:

SPECIAL INSTRUCTIONS:

DATE	TIME	DOSAGE	STAFF	COMMENTS	MED COUNT

INITIALS AND NAME:

