careLOFT day program

P.R.N. AUTHORIZATION

Individual:					
Ht.		Wt.		Date of birth:	

List all allergies and/or adverse reactions to medications

Allergies:

Adverse reactions:

	Medications	Dosage	Measure
☐	**ACETAMINOPHEN**		tablets
☐	**ASPIRIN**		tablets
☐	**COUGH SYRUP**		tablespoon
☐	**DIPHENHYDRAMINE**		tablets
☐	**KAOPECTATE**		tablespoon
☐	**MAALOX**		ounces
☐	**CALAMINE LOTION**	(as required)	
☐	**NEOSPORIN OINTMENT**	(apply to insect bites to relieve itching)	
☐	**A & D OINTMENT**	(for abrasions and cuts)	
☐	**SUNSCREEN**	(for sunburn)	
☐	**NO PRN**		

PARENT/GUARDIAN:	**DATE:**
PHYSICIAN:	**DATE:**

This form is to be reviewed and signed annual prior to the annual PCSP.