



Health Services

Instruction Department

PRN/Short Term Medications

School Year: _____

Name: _____

DOB: _____

Allergies: _____

Campus: _____

Grade: _____

Homeroom: _____

Date: _____										
Medication: _____	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Strength: _____										
Dose: _____	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time
Time: _____										
*Physician's Signature: Y N	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials
**										
Date: _____	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Medication: _____										
Strength: _____										
Dose: _____	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time
Time: _____										
*Physician's Signature: Y N	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials
**										
Date: _____	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Medication: _____										
Strength: _____										
Dose: _____	Time	Time	Time	Time	Time	Time	Time	Time	Time	Time
Time: _____										
*Physician's Signature: Y N	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials

*All medication requires a **Physician's Signature** when given longer than 10 doses or 10 days.

** Place medication count in date boxes.

Comments: _____

Initials Signature

Initials Signature

Initials Signature

Initials Signature