Physician Order Sheet
PRN Medications

Individual's Name:_____ **D.O. B.** _____

Allergies:_____

Month: _____

(Please indicate response by circling either "yes" or "no".)

1.**Acetaminophen (Tylenol) 325 mg**
May give **2 tabs (650 mg total)** by mouth as needed every four hours for complaints of headache, temperature over 101, or pain.

Yes No

2. **Three-in- One Antibiotic Ointment (Bacitracin-Neomycin-Polymyxin B ointment)**
May apply thin layer to surface of cuts/scrapes two times daily as needed until healed. May cover with bandages as necessary.

Yes No

3. Sunscreen
May apply topically to exposed skin 30 minutes prior to sun exposure. May reapply as necessary.

Yes No

4. Other_____
Frequency_____ Dose_____
Other Directions:

5. Other_____
Frequency_____ Dose_____
Other Directions:

Physician's Name: _____

Physician's Signature: _____

Date: _____

Telephone Number: _____