



PRN MEDICATIONS

Name _____ DOB: _____ Allergies: _____

Medication	Route	Dosage	Indication	Order
Ibuprofen 200 mg	Oral	1-2 tabs Q 4 hrs. with food	prn pain or fever	Yes No
Acetaminophen 325 mg	Oral	1-2 tabs Q 4 hrs.	prn pain or fever	Yes No
Benadryl 25 mg	Oral	1 tab Q 6 hrs.	prn allergy symptoms	Yes No
Aleve 220 mg	Oral	1 tab Q 8-12 hrs.	prn significant pain - do not take when taking Ibuprofen	Yes No
Tums	Oral	1-2 tabs chewed Q 2 hrs.	prn heartburn	Yes No
Orajel (Benzocaine)	Topical	rub small amount on affected area up to 4 times a day	prn mouth pain	Yes No
Cough Drops	Lozenge	one Q 1 hour	prn sore throat	Yes No
Betadine Solution	Topical	to clean out a wound	prn wound	Yes No
Bacitracin	Topical	apply thin coat to affected area Q 12 hours	prn open wound	Yes No
Arnica Gel	Topical	apply thin coat to affected area	prn bruise or sprain	Yes No
Aloe Vera Gel	Topical	apply thin coat to affected area	prn sunburn	Yes No
Calamine Lotion	Topical	apply thin coat to affected area	prn itchy rash or bug bites	Yes No
Imodium 2 mg	Oral	2 tabs after first loose stool, then 1 tab after subsequent loose stools	prn diarrhea - 2 or more watery stools in 24 hrs.; no more than 4 tabs/ 24 hrs.	Yes No
Milk of Magnesia	Oral	2 TBS/ 30 mls QD	prn constipation, no BM in 3 days	Yes No
Miralax	Oral	17 Gms in 4-8 oz. water QD for up to 7 days	prn constipation, no BM in 3 days	Yes No
Saline Nasal Spray	Nasal	2 squirts each nostril QID	prn stuffy nose	Yes No
Mucinex 600 mg	Oral	1-2 tabs Q 12 hrs. with full glass of water	prn chest congestion	Yes No

Robitussin	Oral	2 tbsp../10 ml Q4 hrs	prn cough	Yes	No
Robitussin DM	Oral	2 tbsp../10 ml Q4 hrs	prn cough that disrupts sleep	Yes	No
Melatonin 3-6 mg	Oral	30 minutes before bedtime	prn insomnia	Yes	No
Clotrimazole Cream 1%	Topical	apply small amount to affected area twice a day	prn athlete's foot, ringworm, fungal rash	Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

Notes: _____

Prescribers' Signature: _____ **Date:** _____

Service Coordinator's Signature: _____ **Date Received:** _____

Agency Nurse's Signature: _____ **Date Received:** _____

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