Venture COMMUNITY SERVICES

Medication Order Form

Individuals Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Allergies: _____

_____

DRUG NAME	DOSE	FREQUENCY	START DATE	ROUTE	*VITAL SIGNS Y / N	REASON and PARAMENTERS
Acetaminophen	1000mg	PRN q6 hours		PO	N	For fever over 100F or discomfort
Mylanta	30cc	PRN q4 hours		PO	N	For upset stomach
Triple Antibiotic Ointment	Thin Layer	PRN q4 hours		Topical	N	For minor scrapes/abrasions after cleaning
Hydrocortisone Cream 1%	Thin Layer	PRN q4 hours		Topical	N	For rash/itchy skin areas

*Please specify the type of monitoring and parameters if vital signs are required: _____

_____

_____

Print Healthcare Provider Name Title

_____

Signature of Healthcare Provider Date

_____ _____

Posted: Signature Date Time **Verified:** Signature Date Time

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