



**Form D** **Authorised PRN Plan**

Parents, Guardians, or the Individual are to request the person's Doctor to provide instructions about the administration. Please print clearly to ensure this document can be easily read by anyone.

<b>Name of Person: (please print)</b>		<b>Date:</b>
<b>Doctor's Name: (please print)</b>		<b>Drs. Phone No:</b>
		<b>Drs. Fax No:</b>

**Reason for Administering PRN (eg. to control epilepsy, to prevent aggressive outbursts)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Strategies**

**Signs, Behaviours and Conditions** that would require the administration of PRN:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Administering Medication**

Administer \_\_\_\_\_mg. of \_\_\_\_\_ (name of medication). Read Label on Webster pack for procedures or administer \_\_\_\_\_ml or mg. of medication from Non-packed medication with label on bottle or box.

Method Of Administration \_\_\_\_\_

\_\_\_\_\_

I hereby confirm that the instructions detailed above are, in my opinion, appropriate for the administration of PRN medication for the person noted above.

**Doctor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Key person who can be contacted to provide advice about the administration of PRN medication for this person	<b>Name:</b> _____
	<b>Phone No:</b> _____

Agency that employs that key person	
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