Medication Authorization Form

Participant's Name: _____Site: **Civitan Acres - Summer 2019**

Please fill out this form PER MEDICATION.
****To be done by the PHYSICIAN OR DESIGNEE****

Name of medication: _____ **Dosage:** _____

Route: _____ (circle one) **DAILYPRN**

If given daily-specify time(s): _____

If given PRN - *describe:*

Indications: _____ *Frequency*:_____

Reason for Medication: _____

Possible Side Effects:_____

If side effects, occur notify Doctor: Yes__ No__

Restrictions on activity? Yes __ No __

If restrictions, what? _____

What are instructions if the medication is omitted in error and discovered?_____

Less than 8 hours after scheduled dose? _____

More than 8 hours after scheduled dose?_____

When should the patient be re-evaluated? _____

Is this a controlled substance? Yes__ No ___

Physician's signature: _____ Date: _____

Print Name:_____

Address: _____

Telephone: _____Fax: _____

Please note: medications must be delivered as originally dispensed from the pharmacy