FAMILY BUILDERS FOSTER CARE, INC.
PRN AUTHORIZATION LETTER

Patient: _____ (Please print)

Please note that the following "PRN" (as needed) medications may be offered in the resource family homes certified through Family Builders Foster Care, Inc. If you do not object in any of the medications listed below being administered to your patient, please do the following:

- Initial in the "Doctor Approval" section, signifying you approve of this medication for this patient
- If dosage should be changed, please make changes and initial next to your change
- Sign and date page two (2) to acknowledge your decision

If there are other PRN medications that you would prescribe to this client, please list them in the empty boxes below and initial them.

MEDICATION	USED FOR	DOSAGE	DOCTOR APPROVAL
Acetaminophen 250mg	Fever Pain	1-2 tabs q 6 hours Ages 12+ only	
Ibuprofen 200mg	Fever Pain	1-2 tabs q 6 hours Ages 12+ only	
Diphenhydramine HCL (Benadryl)	Sneezing Itchy Watery eyes Runny nose *Separate order needed for any other allergy*	1-2 tsp (5-10ml) Ages 6-12 2-4 tsp (10-20ml) Ages 12+	
Pink Bismuth (Pepto-Bismol) Regular Strength	Heartburn Indigestion Nausea Upset stomach Dirrhea	1 tbsp (30ml) q 1 hour x 2 doses Ages 12+ only	
Antacid (Mylanta)-Extra Strength	Heartburn Indigestion Gas	2-4 tsp (10 – 20ml) between meals as needed Ages 12+ only	
Peroxide	Cuts Scrapes	Apply a small amount over the wound using a cotton ball	Basic First Aid
Triple Antibiotic Ointment	Cuts Scrapes	Apply a small amount to scrape/cut	Basic First Aid
Calamine Lotion	Itching skin	Apply a thin layer to itching skin	Call if not effective
OTHER AS PRESCRIBED BY PHYSICIAN			

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Your completion of this form will serve to document your patient's current ability to determine his or her own need for these medications. As a licensed care provider, it is Family Builders Foster Care's responsibility to monitor your patient's continued ability to determine his or her need for PRN medications and inform you of any changes which indicate he or she can no longer make these decisions.

Please check which circumstances describe your patient:

- ☐ My patient can determine and clearly communicate his or her need for prescription and nonprescription medication on a PRN basis.
- ☐ My patient cannot determine his or her own need for prescription and nonprescription PRN medication, but can clearly communicate his or her symptoms indicating a need for nonprescription medication.
- ☐ My patient cannot determine his or her own need for prescription and nonprescription PRN medication and cannot communicate his or her symptoms indicating a need for a nonprescription medication. Must contact physician before each dose.

_____ _____ _____

Signature of Physician **Printed Name of Physician** **Date**

As the certified foster parent or resource parent, I understand that I am not permitted to give the listed minor or non-minor dependent any PRN medication that the physician did not sign off on.

_____

Signature of Certified/Resource Parent