

As Needed (PRN) Medication Guidelines

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert Date of Birth]

Dear [Insert Parent/Guardian/Caregiver Name],

This letter provides the guidelines for administering "as needed" (PRN) medications for the patient listed above. These medications should only be given when specific symptoms occur.

Medication Name	Dosage	Reason for Use (Symptoms)	Time to Wait Between Doses	Maximum Doses in 24 Hours
[Medication 1]	[Dose amount]	[e.g., Fever or Pain]	[e.g., Every 6 hours]	[e.g., 4 doses]
[Medication 2]	[Dose amount]	[e.g., Shortness of breath]	[e.g., Every 4 hours]	[e.g., 6 doses]

Important Instructions:

- Always document the time and date every time a PRN medication is given.
- Do not exceed the maximum number of doses listed above.
- If symptoms do not improve or if they worsen after treatment, contact a healthcare provider immediately.
- Check the expiration date before administering any medication.

If you have any questions regarding these instructions, please contact [Insert Clinic/Doctor Name] at [Insert Phone Number].

Sincerely,

[Physician Signature]

[Physician Name Printed]

[Clinic Name]