



# Ivey Ranch Park Association – Adult Day Program

## Medication Permission Slip

(Each medication needs a separate permission)

**This form must be filled out by physician**

Participant's Name (*Last, First*): \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Please check one:

☐ **The client is able to determine and communicate his/her need for a prescription or nonprescription PRN medication. Ivey Ranch Park's Adult Day Program staff are permitted to assist the client with self-administration of their PRN medication. (*Latin phrase "pro re nata," which means "as the need arises."*)**

☐ **The client is unable to determine his/her own need for nonprescription PRN medication, but can communicate his/her symptoms clearly, and a designated program staff member is permitted to assist the client with self-administration.**

☐ **The client is unable to determine his/her own need for a prescription or nonprescription PRN medication and is unable to communicate his/her symptoms clearly.**  
*Ivey Ranch Park Adult Day Program requires a prescription / physician's consent for any prescription or nonprescription PRN medication if the client is unable to determine his/her own need for a prescription or nonprescription PRN medication.*

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

At the following time(s): \_\_\_\_\_

This instruction shall be valid until: \_\_\_\_\_

Instructions regarding a time or circumstance (if any) when the medication should be discontinued: \_\_\_\_\_

When should the physician be contacted for medication reevaluation: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Participant's Signature: \_\_\_\_\_

Parent/Authorized Representative's Signature: \_\_\_\_\_