100 Poplar Ave Sierra Vista Child & Family Services Modesto, CA 95354

TECHNICAL SUPPORT PROGRAM
PRN AUTHORIZATION LETTER

Dear Dr.____, Date:___________________

Your patient______________________________, is placed in one of our Resource Homes. In order for us to comply with state regulations, we need to have a statement from his/her physician, stating he/she is capable of asking for his/her own over the counter medications on a PRN basis. This statement will enable us to give the above patient aspirin, etc. when requested. *Medication will be dispensed and supervised by a Sierra Vista Child & Family Services resource parent.* If the patient is on any prescription medication that is to be taken on a PRN basis, we also need to have a statement saying the patient is capable of asking for the following PRN prescribed medications and listing the medication.

Thank you for your assistance in this matter,

Sincerely,

____

My patient, ________________________, is or is not (circle one) capable of asking for over the counter medication on a PRN basis.

Physician's Signature ____

My patient, ______________________________, is or is not (circle one) capable of asking for these following prescribed medications on a PRN basis.

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

Physician's Signature ____