MEDICATION ORDER

To be completed by licensed prescriber, physician, nurse practioner or others authorized by Chapter 94C

Name of Student _____ Date of Birth _____

Address _____ Grade _____
(Street) (City/Town)

Name of Licensed Prescriber _____ Title _____

Business Tel. Number _____ Emergency Tel. Number _____

Medication _____

Route of administration _____ Dosage _____

Frequency _____ Time(s) of Administration _____
(Please note: Whenever possible, medication should be scheduled at times other than school hours.)

Specific directions of information for administration: _____

Date of Order _____ Discontinuation Date _____

Diagnosis* _____

Any other medical condition(s)* _____

Optional Information

1. Specific side effects, contraindications, or possible adverse reactions to be observed: _____

_____

2. Other medication being taken by the student: _____

_____

3. The date of the next scheduled visit or when advised to return to prescriber: _____

4. Consent for self administration (provided the school nurse determines it is safe and appropriate).

Yes_____ No _____

_____
Signature of Licensed Prescriber

* If not in violation of confidentiality