MEDICATION ORDER

(to be completed by a Licensed Prescriber, Physician, Nurse Practitioner, or others authorized by Chapter 94C)

Name of Student_____Date of Birth_____Grade_____

Address_____
(Street) (City / Town)

Name of Licensed Prescriber_____Title_____

Business Telephone_____ Emergency Telephone_____

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 or information for administration:_____

Date of Order_____ Discontinuation Date_____

Diagnosis*_____

Any other medical condition(s)*_____

Optional Information

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

2. Other medication being taken by 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