MEDICATION ORDER

TO BE COMPLETED BY A LICENSED PRESCRIBER

(Physician, Nurse Practitioner, or others authorized by Chapter 94C)

Name of Student_____ Date of Birth_____

Address

(street) *(city/town)*

Name of Licensed Prescriber_____ Title_____

Business Telephone Number _____ Emergency Telephone Number_____

Medication _____

Route of administration _____Dosage_____

Frequency

Please note:

1. Whenever possible, medication should be scheduled at times other than school hours.
2. Over-the-counter medications will require a written order to be administered in school.

Specific directions or information for administration: _____

Date of Order _____ Discontinuation Date _____

Diagnosis* _____

Any other medical condition(s)* _____

Additional Information

1. Special 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*