Medication Order

Must be completed by a licensed prescriber:
Physician, Nurse Practitioner or others authorized by Chapter 94C

Name of Student:____________________________________ Date of birth:___________________

Address:____ Grade:_____________

Name of Licensed Prescriber:____________________________________ Title:________________

Telephone Number:_________________________ Emergency 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 for administration:____

Date of order:__________________________ Discontinuation Date:________________________

Side effects, contraindications, or adverse reactions:___________________________________

____

Other medication being taken by student:____

Date of next follow-up:____

Consent for self-administration (provided the school nurse determines it is safe and appropriate) **Yes** ______ **No** ______

*Diagnosis:____

*Any other medical contitions?:____

*** If not in violation of confidentiality**

____ ____________________________
(Signature of Licensed Prescriber) (Date)