

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 _____ Grade _____
(street) (city/town)

Name of Licensed Prescriber _____ Title _____

Business Telephone Num. _____ Emergency Telephone Num. _____

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 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