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 ________

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Signature of Licensed Prescriber

*if not in violation of confidentiality

MDPH - Sample