

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: _____

City, State: _____ Zip: _____

Name of Licensed Prescriber: _____ Title: _____

Business Phone: _____ Emergency Phone: _____

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.