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 _____Emergency No._____

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)

*** Please attach action plan

Optional Information:

1. Special side effects, contraindications, or possible adverse reactions to be observed:
2. Other medication being taken by student:_____

3.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.