Saint Mary School
16 Summer Street, Shrewsbury, MA 01545
Telephone: 508-842-1601, Fax: 508-845-1535

MEDICATION ORDER FORM

(To be completed by a Licensed Prescriber: Physician, Nurse Practitioner or others authorized by Chapter 94C)

Name of Student:_____**Date of Birth:**_____**Grade:**_____

Address:_____
(Street) (City) (State) (Zip)

Diagnosis:_____
(If not in violation of confidentiality)

Any other medical condition(s):_____
(If not in violation of confidentiality)

ALLERGIES_____

DATE OF ORDER:_____ **Discontinuation Date:**_____

NAME OF MEDICATION:_____

Route:_____ **Dose**:_____

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:_____
_____

OVER THE COUNTER MEDICATIONS(s) Route Dose Frequency Time(s)Administration

Ibuprofen_____
Jr. Strength Motrin_____
Advil_____
Advil Cold and Sinus_____
Jr. Strength Advil_____
Aleve_____
Tylenol_____
Acetaminophen_____
Jr. Strength Tylenol_____
Cough Drops_____
Cough Syrup (name)_____
OTHER_____

- **Special side effects, contraindications, or possible adverse reactions to be observed:**_____
  _____
- **Other medication being taken by the student:**_____
  _____
- **Date of next scheduled visit or when advised to return to Prescriber:**_____
- **Consent for self administration (provided the School Nurse determines it is appropriate):**
  Yes_____ **No**_____

SIGNATURE OF LICENSED PRESCRIBER:_____**DATE:**_____
Printed Name of Licensed Prescriber:_____
Business telephone number:_____