J. Brooks Hoffman '36 Health Center
Blair Academy

healthcenter@blair.edu
(phone) (908)362-6121, ext. 5625 (fax) 908-362-7885

Off Campus Health Care Provider Visit Form

To the EXAMINING HEALTH CARE PROVIDER:

In order to ensure that the Health Center has a completed and updated health record for our mutual patient/student and for communication purposes if the Health Center has a question, please complete the information below and STAMP in the space provided.

Thank you for your cooperation.

Student Name: ____

*Date:*____

*Diagnosis:*____

Follow up Care Recommended:

*Limits on Physical Activity?*_________________________________

*Return Visit?*____

HISTORY REVIEWED and STUDENT EXAMINED BY: **<u>Professional Designation</u>:** ❑ **MD/DO** ❑ **APN** ❑ **PA** ***Please note Health Care provider must be someone other than a parent.***	**PHYSICIAN/HEALTHCARE PROVIDER STAMP** ***Please note Health Care provider must be someone other than a parent.***

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MEDICATION ORDER FORM 2019-2020

HEALTH CARE PROVIDER to complete *if applicable*

NOT APPLICABLE

STUDENT NAME:____________________DATE OF BIRTH:___________________________
DIAGNOSIS:____

Dear Licensed Prescriber:

Your patient is a student at Blair Academy and is under your care regarding the management of a prescription medication. School and state regulations require that these medications be administered from the school's Health Center and that a written medication order from the licensed prescribing provider be kept on file in the student's medical record.

We work with ***North Warren Pharmacy, 908-362-5156, 155 NJ Route 94 Blairstown, NJ 07825*** for prescriptions, refills and blister packaging. ***ALL medications must be blister packed; no exceptions***. Please be sure to discuss a plan for your patient to obtain refill prescriptions from you so that there is little or no interruption of his/her medication. Please feel free to contact the Health Center directly with any questions.

Please note Health Care provider must be someone other than a parent.

Prescribing Provider
Signature:_______________________________DATE:_______________________________
Address:____
Phone:____FAX:________________

MEDICATION ORDERING INFORMATION

Medication Name	Dose	Frequency	Route	PRN only (YES OR NO?)	Administer Stimulants on Class Days only (Yes or No)	Notes/ Diagnosis

Please present this completed form, along with the medication, to the Health Center upon arrival at school.