BOURNE PUBLIC SCHOOLS

LICENSED PRESCRIBER
MEDICATION ORDER

Name of Student ______________________________ Date of Birth______________

Name of Prescriber____________________________ Phone____________________

Medication___________________________________ Diagnosis*________________

Dosage_________ Route________ Frequency________ Time of Day _______

Date of Order______________ Discontinuation Date__________________________

Intended effect of this medication ____________________________________

Any other medical conditions* ____________________________________
Other medication being taken by the student*____________________________________

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Consent for self-administration (provided the nurse determines it is safe and parent is in agreement). Yes No

Signature of Prescriber___________________________ Date_____________

Medication cannot be transported to school by the student and will be destroyed if it is not picked up within one week following termination of the order or by the last day of the school year.

**if not in violation of confidentiality*

MD medication order form.doc
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