MEDFORD PUBLIC SCHOOLS
Health Services Department

Medication Order Form
To be completed by a licensed prescriber

Student's name_____ Date of Birth_____

Address: _____ Grade:_____

Name of Licensed Prescriber: _____

Business Telephone Number: _____

Medication Order Details:
Medication: _____ Route: _____ Dose: _____ Time of Administration: _____ Frequency: _____ Diagnosis: _____
Specific Directions or Information for Administration:
Order Dates:
Date of Order: _____ Date of Discontinuation: _____

I give permission for this child to self-administer medication, if the school nurse determines it is safe and appropriate.

☐ Yes
☐ No

Licensed Prescriber Signature_____ Date_____