Old Rochester Regional School District
Massachusetts School Superintendency Union #55
MEDICATION ORDER

Name of Student _____Date of Birth_____

Diagnosis*_____Other medical condition*_____

Medication_____Dosage_____Route_____

Frequency_____ Times 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_____
Optional Information
1. Side effects, contraindications, adverse reactions: _____
2. Other medication taken by student: _____
3. Date of next scheduled visit: _____
4. Consent for self-administration (provided the school nurse determines it is safe and appropriate).
Yes_____ No_____

_____
Signature of Licensed Prescriber

_____
Name Printed

_____
Business/Emergency Telephone

*If not in violation of confidentiality

_____
WRITTEN PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

1. I give permission to the school nurse to give the following medication_____

prescribed by _____to my child_____
2. I give permission for my child to self-administer medication if the school nurse determines it is safe and appropriate. Yes_____ No_____
3. I give permission to the school nurse to share with school personnel information relative to this medication as determined necessary for my child's safety and health.
Restrictions_____
4. I give permission to the school nurse to consult with the above physician as needed regarding this order.

Date_____ Signature of Parent/Guardian _____

Relationship to Student _____ Name Printed _____

Known Allergies _____ Emergency Telephone Numbers _____

Other medications currently receiving_____
Other emergency contact if parent unavailable_____