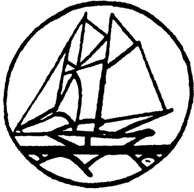

Sippican School

16 Spring St, Marion, MA 02738 / Phone: (508)748-0100 FAX: (508)748-1953

Medication Order Form

(to be completed by a licensed prescriber)

Name of Student_______________________________________ Date of Birth _________

Address____ Grade _____________

(street) *(city/town)*

Name of Licensed Prescriber_________________________________ Title________________

Business Phone_________________________ Emergency Phone______________________

Medication____

Route of administration________________________________ Dosage_________________

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: _____________________________________

____

Date of Order______________ Discontinuation Date_________________

Diagnosis*____

Any other medical condition(s)*____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed:____
2. Other medication being taken by the student:____
   ____
3. The date of the next scheduled visit or when advised to return to prescriber: _______________
4. Consent for self administration (provided the school nurse determines it is safe and appropriate).

Yes_____ No_____

____

Signature of Licensed Prescriber

* if not in violation of confidentiality.