MONOMOY REGIONAL SCHOOL DISTRICT
Medication Order Form To Be Completed By Licensed Prescriber

Name of Student_____ Date of Birth_____

Address_____Grade ____

Name of Licensed Prescriber _____ Telephone # (___)_____

Address_____

Medication_____ Dosage_____Route _____

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 medications being taken by the student:_____

3. 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: _____ Date: _____

* If not in violation of confidentiality.