DUDLEY-CHARLTON REGIONAL SCHOOL DISTRICT

Medication Order

(to be completed by Physician, Nurse Practitioner or others as authorized by Chapter 94C)

Name of Student: ____DOB: ____________

Address: ____

Allergies:____

Name of Licensed Prescriber:____

Diagnosis*: ____

*if not in violation of confidentiality

Name of Medication: ____

Dose: ____________________________ Route of administration:________________________

Frequency:__________________________ Time(s) of administration:____________________

Additional instructions:____

Side effects, contraindications, or possible adverse reactions:_____________________________

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Student may self-administer this medication with permission of parent/guardian and consent of the school nurse:

⬜Yes ⬜ No

Date of Order: ____________________________Discontinuation Date: ____________________

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Signature of Licensed Prescriber

Reviewed 5/2026