

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*