

MEDICATION ORDER

(To be completed by a Licensed Prescriber: Physician, Nurse Practitioner,
Or others authorized by Chapter 94C)

Name of Student _____ Date of Birth _____

Address _____ Grade _____

Name of Licensed Prescriber _____ Title _____

Business Telephone # _____ Emergency Telephone # _____

Medication _____

Dosage _____ **Route of Administration** _____

Frequency _____ **Time(s) of Administration at School** _____

(Please note: Whenever possible, medication should be scheduled at times other than school hours.)

Consent for self-administration (provided the school nurse determines it is safe and appropriate). Yes _____ No _____

Specific directions or information for administration: _____

Date of Order: _____ Discontinuation Date: _____

Diagnosis _____

Any other medical condition(s) _____

Special side effects, contraindications, or possible adverse reactions to be observed:

Other medication being taken by student: _____

The date of the next scheduled visit or when advised to return to prescriber: _____

Signature of Licensed Prescriber

Date