Medication Order

To be completed by a Licensed Prescriber, Physician, Nurse Practitioner or others authorized by Chapter 94C

Student Information

Name and Address	Date of Birth
	Grade

Medication Information

Medication	Route of Administration
	Dosage
Specific Directions or Information for administration	Frequency
	Time(s) of Administration
Diagnosis (if not in violation of confidentiality)	Date of Order
	Discontinuation Date

Other Medical Condition(s)

Describe

Pertinent Information

1) Special side effects, contraindications, or possible adverse reactions to be observed:	
2) Other medications being taken by the student	
3) The date of the next scheduled visit or when advised to return to the prescriber:	
4) Consent for self administration (provided the school nurse determines it is safe and appropriate):	Yes No

Licensed Prescriber

Name and Title	Business Phone Number
	Emergency Phone Number
Signature	Date