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_____
(Street) (City/town) (Zip)

Name of Licensed Prescriber_____ Title_____

Business Telephone No._____Emergency Telephone No._____

Medication_____

Route of administration_____Dosage_____

Frequency_____Time(s) of Administration_____

Specific directions or information for administration_____

Date of Order_____ Discontinuation Date_____

Diagnosis*_____

Any other medical condition(s)_____

PERTINENT INFORMATION

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

_____

2. Other medication 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_____

_____

Signature of Licensed Prescriber

*If not in violation of confidentiality