

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

Name of Student _____ DOB ____ / ____ / ____

Address _____ Grade _____

Name of Licensed Prescriber _____ Title _____

Business Telephone # ____ - ____ - ____ Emergency Telephone # ____ - ____ - ____

Name of Medication _____

Dosage _____ Route _____ Frequency _____

Time(s) of Administration in school _____

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

Date of order _____ Discontinuation Date _____

Specific directions or information for administration: _____

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:

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