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 Number: _____
Emergency Telephone Number: _____

Medication: _____

Dosage: _____ Route of Administration: _____

Frequency: _____ Time(s) of Administration in school: _____
(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*: _____

Allergy: _____

Any other medical condition(s)*: _____

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

ADDITIONAL INFORMATION

1. Specific 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: _____

Signature of Licensed Prescriber: _____
Date: _____

*If not in violation of confidentiality