

MEDICATION ORDER

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

(The following section must be filled in completely)

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) to be administered at 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\* \_\_\_\_\_

Any other medical condition(s)\* \_\_\_\_\_

Optional 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 prescriber:

\_\_\_\_\_

4. Consent for self-administration (provided the school nurse determines it is safe and appropriate). Yes \_\_\_ No \_\_\_ ("Self-administration" defined as staff-supervised. - not nurse supervised - administration of medications under control of the school.)

\_\_\_\_\_  
Signature of Licensed Prescriber

\*if not in violation of confidentiality