MEDICATION ORDER

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

Name of Student: _____ **Date of Birth:** _____

Street Address: _____ **Grade:** _____

City/Town: _____

Name of Licensed Prescriber: _____ **Title:** _____

Business Telephone Number: _____

Emergency Telephone Number: _____

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)*: _____

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: _____
   _____
4. Consent for the self-administration if the medication ordered is an inhaler for asthma or Epinephrine for an allergic reaction. (Provided the school nurse determines it is safe and appropriate). Yes_____ No_____

Signature of Licensed Prescriber: _____

*If not in violation of confidentiality