STUDENT MEDICATION ORDER FORM

(To be Completed by a licensed Prescriber: Physician, Nurse Practitioner or Others Authorized by Chapter 94C)

Today's Date: _____

Name of Student: _____ Date of Birth: _____

Address: _____ Grade: _____
(Street) (City/Town)

Name of Licensed Prescriber: _____ Title: _____

Business Telephone: _____ Emergency Telephone: _____

Medication(s): _____

Route(s) of Administration: _____ Dosage(s): _____

Frequency: _____ Time(s) of Administration: _____
(Please Note: Whenever possible, medication should be scheduled at times other than school hours.)

Specific Directions or Information for Administration: _____

Date(s) of Order: _____ Discontinuation Date(s): _____

Diagnosis(es): _____

**Any Other Medical Condition(s): _____
**If not in violation of confidentiality.

Optional Information:

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

   _____

2. Other medications 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 _____

_____
Signature of Licensed Prescriber