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