

School Union 61

BRIMFIELD - BROOKFIELD - HOLLAND - STURBRIDGE - WALES

MEDICATION ORDER

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

Name of student _____ Date of Birth _____

Address _____ Grade ____
(street) (city/town)

Name of Licensed Prescriber _____ Title _____

Business Telephone # _____ Emergency Telephone # _____

Medication _____

Route of administration _____ Dosage _____

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

Signature of Licensed Prescriber

*Not in violation of confidentiality.