



## MEDICATION ORDER FORM

*To be completed by licensed prescriber*

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Grade: \_\_\_\_\_  
(street) (city)

Name of Licensed Prescriber: \_\_\_\_\_ Title: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_

Emergency Telephone Number: \_\_\_\_\_

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 student:

\_\_\_\_\_  
\_\_\_\_\_

3. Date of next scheduled visit or when advised to return to prescriber: \_\_\_\_\_

4. Consent for self-administration (provide the School Nurse determines it is safe and appropriate).

\_\_\_\_\_ Yes \_\_\_\_\_ No

Signature of Licensed Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

\* if not in violation of confidentiality