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