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