MEDICATION ORDER - (To Be Completed By A Licensed Prescriber)

Name of Student _____D.O.B. _____

Address _____ Grade _____

Name of Licensed Prescriber _____Business Phone_____
Please Print

Medication_____

Route of Administration _____ Dosage _____

Frequency _____ Time of Administration _____

Whenever possible, meds should be scheduled at times other than school hours.

Date of Order _____ Discontinuation Date _____

Diagnosis (if not in violation of confidentiality) _____

Other Medical Condition(s) _____

Optional Information:

1. Special side effects, contraindications, or possible adverse reactions to be observed

   _____

2. Other medications being taken by student: _____

3. The date of next scheduled visit or when advised to return to prescriber_____

4. CONSENT TO CARRY AND SELF ADMINISTER MEDICATION (provided the school nurse determines it safe and appropriate) Yes _____ No _____

_____ _____
Signature of Licensed Prescriber Date