

Prescription Medication Order

**To be completed by a Licensed Prescriber, Physician,
Nurse Practitioner or others authorized by Chapter 94C**

Name of Student: _____ DOB: _____

Address: _____ Grade: _____

Name and Title of Prescriber: _____

Phone number(s): _____

Medication name: _____

Dosage: _____ Route of administration: _____

Frequency: _____ Time(s) of administration: _____

****Whenever possible, medication should be scheduled at times other than school hours****

Specific directions or information, if any, for administration: _____

Date of order: _____ Discontinue date: _____

Diagnosis*: _____

Any other medical condition(s)*: _____

***If not in violation of confidentiality**

Optional information

1. Side effects, contraindications, or possible adverse reactions that may occur: _____

2. Other medications taken by student: _____

3. Date of next scheduled visit or when advised to return to Prescriber: _____

Signature of Licensed Prescriber