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: ___________________

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Signature of Licensed Prescriber