MEDFORD PUBLIC SCHOOLS

Medford, Massachusetts

Medication Order Form to be completed by a licensed prescriber

Name of Student_______________________________________Date of Birth __________________

Address____ Grade___________________
Street (city/town)

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 conditions(s)*____

Optional Information

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

2. Other medication being taken by the student:____

   ____

3. The date of the next scheduled visit or when advised to return to prescriber:______________________

   ____

4. Consent for self administration (provided the school nurse determines it is safe and appropriate).

   Yes________ No___________

____
Signature of Licensed Prescriber

Date: _____________________________

* if not in violation of confidentiality