

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

