Medication Administration Order Form

Form to be completed by Licensed Prescriber; Physician, Nurse Practitioner or others authorized by Chapter 94C

Student's Name____ D.O.B.________________

Address_____________________ Town_____________________ Grade_________________

Name of Licensed Prescriber _______________________________ Title ________________

Business Telephone # _________________________ Emergency Telephone #____________

Medication Name ____

Route of Administration _____________________________ Dosage ____________________

Frequency _____________________ Time 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

Please return form to the Special Education Office-Attn.: Barbara McDaniel