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2011-2012

Medication order (To be completed by Licensed Prescriber)

Student: _____ Date of Birth _____ Grade _____

Name of Licensed Prescriber: _____

Business Phone: _____ Emergency Phone: _____

Medication Prescriber (Dose, Frequency & Route) _____

Time(s) of Administration: _____ (Please note: whenever possible, medication should be scheduled at times other than school hours).

Specific Instructions re: administration (if any): _____

Date of Order: _____ Discontinuation Date: _____

Diagnosis (if not violation of confidentiality): _____

Any other medical conditions relevant to medication prescribed (if not in violation of confidentiality): _____

Optional Information:

1. Specific side effects, contraindications, or possible adverse reactions to be observed: _____
2. Other medications being taken by student: _____
3. Consent for self administration (provided the school nurse determines it is safe and appropriate) ___ Yes ___ No

Signature of Licensed Provider: _____ Date _____

Parent/Guardian

I request that my child _____ receive the medication prescribed on the form above by _____.

(Licensed Prescriber)

Signature of Parent/Guardian

Telephone Number

Date

