Sample 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 Phone_____ Emergency Phone_____
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 condition(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

* if not in violation of confidentiality.