

## Medication Order Form

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 \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

\* if not in violation of confidentiality.