



Fernando M. Goulart, Executive Director

## 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