

**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.