



Medication Order Form

(to be completed by a Licensed Prescriber)

Name of Student: _____ Date of Birth: _____

Name of Licensed Prescriber and Title: _____

Prescriber Business Phone: _____

Prescriber Emergency Phone: _____

Medication: _____ Dosage: _____

Frequency: _____ Time(s) of Administration: _____

Date of Order: _____ Discontinuation Date: _____

Diagnosis* and reason for giving medication: _____

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. 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