LANDMARK SCHOOL

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*:_____

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:
_____

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.