MEDICATION ORDER FORM

TO BE COMPLETED BY LICENSED PRESCRIBER

Student's Name ______________________________________Date of Birth _________________

Address ____ Grade ____________

Name of Licensed Prescriber ____

Phone Number____

Diagnosis ____

Medication # 1__________________________________ Dosage ___________________

Route of Administration ________________________ Frequency __________________

Specific directions or information for administration _____________________________

____

Date of Order ________________________ Discontinuation Date __________________

Consent for self-administration (provided the school nurse determines it is safe and appropriate).
Yes _____ No _____

Medication # 2_______________________________ Dosage _____________________

Route of Administration ________________________ Frequency __________________

Specific directions or information for administration _____________________________

____

Date of Order ________________________ Discontinuation Date __________________

Consent for self-administration (provided the school nurse determines it is safe and appropriate).
Yes _____ No _____

Signature of Licensed Prescriber ____

Date ______________________