WESTON
PUBLIC SCHOOLS
WESTON, MASSACHUSETTS 02493 • TEL. 781-786-5830
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HEALTH SERVICES

MEDICATION ORDER

(to be completed by a Licensed Prescriber—
Physician, Nurse Practitioner or others authorized by Chapter 94C)

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):* _____

Additional 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 of inhaler or epi-pen or medication that may need to be immediately administered for diagnosed severe medical conditions (provided the School Nurse determines it is safe and appropriate):

   Yes: _____ No: _____

_____
Signature of Licensed Prescriber

*If not in violation of confidentiality