KING PHILIP REGIONAL SCHOOL DISTRICT

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 Telephone #: _____ Emergency Telephone # _____

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 administrations: _____

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