**STOUGHTON PUBLIC SCHOOLS**
**MEDICATION ORDER FORM**
(To be completed by a licensed prescriber as defined in MG.L c 94C)

Name of Student: _____ Date of Birth: _____
Address: _____ Grade: _____
Name of Licensed Prescriber: _____ Title: _____
(please print)
Business Telephone Number: _____
Emergency Telephone Number: _____

Date of Order: _____ Discontinuation Date: _____
Medication Name: _____ 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/information for administration: _____
*Unless medically contraindicated or otherwise noted by the prescriber, medication may be given 30mins before or after ordered time.*

Consent for self-administration: ☐ Yes ☐ No
*Provided that it is consistent with school policy, and that the school nurse determines it is safe, appropriate and all requirements listed in MADPH regulations 105 CMR 210.000 are met.*

* Diagnosis: _____
* Other medical condition (s) requiring medication: _____
* Other medications being taken by the student: _____
  * if not in violation of confidentiality or if not contrary to the request of a parent, guardian, or student to keep confidential.

Any known allergies (food/meds): _____

Side effects, contraindications and adverse reactions to be observed: _____
_____

The date of return visit, if applicable: _____

_____ _____
Signature of Licensed Prescriber Date