MAYNARD

PUBLIC SCHOOLS

HEALTH SERVICES DEPARTMENT

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MEDICATION ORDER

To be completed by a licensed Prescriber: Physician, Nurse Practitioner or others authorized by Chapter 94C.

Student Name: ____ Date of Birth: _____________

Diagnosis: ____

Date of Order: __________________________ Discontinuation Date: __________________________

Medication: ____________________________ Dosage: _______________ Route: _______________

Frequency: ____________________________ Time to be given at school: ______________________

PLEASE NOTE: Medication should be scheduled at times other than school hours whenever possible.

Known Allergies: ____

Any other medical conditions: ____

Specific directions or information for administration: ____

OPTIONAL INFORMATION

1. Special side effects, contraindications, or possible adverse reactions to be observed: _______
   ____
2. Other medications being taken by student: ____
3. Date of 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 o **NO** o

Name of Licensed Prescriber: ____

Business Phone: __________________________ Emergency Phone: __________________________

Signature of Licensed Prescriber: ____

Date: _____________________