ROCKLAND PUBLIC SCHOOLS
ROCKLAND, MASSACHUSETTS

Medication Order Form to be completed by a Licensed Prescriber

Student's Name _____ **Date of Birth** _____

Address _____ **Grade** _____

Name of Licensed Prescriber _____ **Title** _____

Business Telephone Number _____

Emergency Telephone Number _____

Medication _____

Route of Administration _____ **Dosage** _____

Frequency _____ **Time(s) of Administration** _____
(Please note: Whenever possible, medication should be scheduled at other than school times.)

Specific directions or information for administration _____

_____

Diagnosis (If not in violation of confidentiality) _____

Any other medical conditions (If not in violation of confidentiality) _____

_____

Optional Information

1) Special side effects, contraindications, or possible reactions to be observed:

_____

2) Other medications taken by this 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 safe and appropriate) ☐ **Yes** ☐ **No**

Date of Order _____ **Discontinuation Date** _____

Signature of Licensed Prescriber _____