Haverhill Public School Health Department

School Health Services

Medication Order Form

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

Name of Student____ Date of Birth __________

Address____ Grade ________

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)* ____

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.

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