MARBLEHEAD PUBLIC SCHOOLS MEDICATION ORDER

(to be completed by a Licensed Prescriber:
Physician, Nurse Practitioner, or others authorized by Chapter 94C)
Return to your School Nurse

Name of student: _____Date of Birth:_____

Address:_____Grade:_____
(Street) (City/town)

Name of Licensed Prescriber:_____Title:_____

Business Telephone:_____Emergency Number:_____

Medication:_____

Route of administration:_____Dosage:_____

Frequency:_____Time of administration:_____

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 medications 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 safe and appropriate): Yes_____ No_____

_____
(Signature of Licensed Prescriber)

*if not in violation of confidentiality