CONCORD MIDDLE SCHOOL
Concord, Massachusetts

MEDICATION ORDER FORM

(To Be Completed By A Licensed Prescriber)

Student Name:_____ Date:_____
Last First Middle

Home Address:_____School/Grade:_____

Licensed Prescriber:_____ Title:_____
Name

Business Phone:_____ Emergency Phone:_____

Medication:_____ Dosage:_____

Frequency:_____Time(s) 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 conditions(s)*****:_____

Optional Information

1. Special side effects, contraindications, or possible adverse reacions 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 Date

*****if not in violation of confidentiality