DUDLEY-CHARLTON REGIONAL SCHOOL DISTRICT

Doctor's Treatment Order

To be completed by the Physician, Nurse Practitioner, or others as authorized by Chapter 94C

Name of Student_____ DOB_____
(Please print)

Address of Student_____
(street) (city/town) (zip)

Emergency Telephone_____ Work Telephone_____

Treatment_____
_____
_____

Frequency/Time_____

(Please be specific, daily, BID, TID, QID, etc)

Date of Order_____ Discontinuation of Order_____

Any other medical
condition(s)_____
_____
_____

Optional Information

1. Medication taken by
   student_____
   _____
   _____
2. The date of the next scheduled visit or when advised to return to
   prescriber_____
   _____

_____

Signature of Licensed Prescriber

"…to advance the knowledge and well-being of our children and our communities."