DUDLEY-CHARLTON REGIONAL SCHOOL DISTRICT

Medication Order

(to be completed by Physician, Nurse Practitioner, or others as authorized by Chapter 94C

Name of Student_____DOB_____
Please print

Address_____
(street) *(city/town)* *(zip)*

Emergency Telephone_____Work Telephone_____

Name of Licensed Prescriber:_____

Diagnosis*_____
if not in violation of confidentiality

Medication_____Dosage_____

Frequency/Time_____
(whenever possible, medication should be scheduled at times other than school hours)

Date of Order_____Discontinuation Date_____

*Any other medical condition(s)*_____

Optional Information

*1. Special side effects, contraindications, or possible adverse reactions:*_____

*2. Other medication taken by 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