BROCKTON PUBLIC SCHOOLS

Medication Order Form To Be Completed By Licensed Prescriber

Name of Student_____ Date of Birth_____

Address_____ Brockton, MA. 0230___ Grade ____ Room_____

Name of Licensed Prescriber _____Tele.# (____)_____

Address_____

Medication_____Dosage_____Route _____

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

Date: _____

*** If not in violation of confidentiality.**