EASTON PUBLIC SCHOOLS
MEDICATION ORDER
(To be completed by a Licensed Prescriber:
Physician, Nurse Practitioner or others authorized by Chapter 94C)

Name of Student:________________________D.O.B.________Sex:______Grade:__________

Address:________________________City:________________State:_______Zip Code:________

Name of Licensed Prescriber:____

Business Phone :_____________________Emergency Phone :_________________________

Name of Medication:____

Route of Administration:___________________________Dosage:_________________________

Time(s) of Administration:______________________________ Frequency________________

(Please note: Whenever possible, medication(s) should be scheduled at times other than school hours).

Specific directions or information for administration (i.e. specify signs and symptoms that warrant if medication should be given immediately):_________________________________

____

____

Date of Order:________________ Discontinue Date:_________________________________

Diagnosis*____

Any other medical condition(s)*____

<u>Additional Information</u>

1. Specific side effects, contraindications, or possible adverse reactions to be observed:____
   ____
2. Other medication being taken by the student:____________________________________
   ____
3. Date of next scheduled visit or when advised to return to prescriber:_________________
4. Consent for self-administration (if applicable and provided the school nurse determines it is safe and appropriate). • Yes • No

_____________________________________ ___________________
(Signature of Licensed Prescriber) **(Date)**

*** If not in violation of confidentiality**