ATTLEBORO PUBLIC SCHOOLS
Health Services

MEDICATION ORDER
(To be completed by a licensed prescriber)

Name of Student _____ Date of birth _____

Address _____ Grade _____
(street) (city/town)

Name of Licensed Prescriber _____ Title _____

Business Phone _____ Emergency Phone _____

Medication _____

Route of administration _____ Dosage _____

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

*if not in violation of confidentiality

Revised: 1/2012