SALEM PUBLIC SCHOOLS
HEALTH SERVICES

Medication Order (to be completed by a Licensed Prescriber: Physician, Nurse Practitioner or others authorized by MGL Chapter 94C)

Name of Student: _____Date of Birth_____

Address:_____ Grade: _____

Name/Title of Licensed Prescriber:_____

Business Telephone #._____ Emergency #._____

FAX: _____

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(s) being taken by the student:
_____

3. 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