Salem Public Schools
School Health Services

Licensed Provider Medication Order

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

Name of Student: _____ Date of Birth: _____

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

Name/Title of Licensed Prescriber: _____

Phone:_____ Emergency Phone: _____ 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*

Revised 10/10//17 JCM