

YOUR SCHOOL DISTRICT
LICENSED PRESCRIBER MEDICATION ORDER FORM

Student Name: _____ DOB: _____

PRESCRIBER INFORMATION:

1. Licensed Prescriber's Name: _____

2. Title: MD DO NP PA Other: _____

3. Business Phone: _____ Fax: _____

MEDICATION INFORMATION:

Whenever possible, please try to scheduled medication at times other than school hours.

1. Child's Diagnosis: _____

2. Medication Name: _____

3. Dose: _____ Frequency: _____

3. Route: PO Inhaled IM SC Other: _____

4. Additional directions or instructions for administration: _____

5. Side effects school staff should be aware of (please list): _____

6. Start Date: _____ End Date: _____

7. Other medication student is taking: _____

8. Date of next scheduled visit or when advised to return for follow up: _____

9. Can student self-administer this medication (if school nurse determines it is safe and appropriate): Yes No

PLEASE NOTE: STUDENTS ARE NOT ALLOWED TO SELF-ADMINISTER CONTROLLED SUBSTANCES (I.E. RITALIN, ETC.)

Date: _____ Prescriber's Signature: _____

Please return this form to: (building, nurse's name, phone, fax)