Dennis-Yarmouth Regional School District

Medication Order

(To be completed by a licensed Prescriber: Physician, Nurse Practitioner or others authorized by chapter 94C)

Student's name _____ Date of Birth _____

Address _____Grade _____

Name of Licensed Prescriber _____ Title _____

Business telephone_____ Emergency #_____

Medication_____

Dosage _____ Route of administration_____

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 conditions (s)*_____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed _____
2. Other medications being taken by the student_____
3. The date of the next scheduled visit or when advised to return_____
4. Consent for self administration (provided the school nurse determines it is safe and appropriate) Yes_____ No_____

_____

Signature of Licensed Provider Date

*if not in violation of confidentiality