BISHOP STANG HIGH SCHOOL

PHYSICIAN MEDICATION ORDER

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

Student's Name: _____ D.O.B.: _____ Grade: _____

Address: _____ City: _____ State: ____

This section to be completed by Licensed prescriber only:

Medication: _____ Dosage: _____

Route: _____ Time(s) of Administration: _____

Frequency: _____

Please note: Whenever possible, medications should be scheduled outside of school hours.

Specific directions or information for administration (i.e. specific signs and symptoms that warrant medication should be given immediately): _____

_____

Date of Order: _____ Discontinue Date: _____or end of school year

Diagnosis*****: _____

Any other medical condition(s)*****: _____

_____

**Complete only if not in violation of confidentiality*

Additional Information:

- **Specific side effects, contraindications, or possible adverse reactions to be observed:**
  _____
  _____
- **Consent to self-administer** (if applicable and if the school nurse determines it safe and appropriate): **YES** **NO**

Licensed Provider Signature: _____ Date: _____

Name of Licensed Provider: _____ Phone: _____