Buckingham Browne & Nichols School Health Services

Medication Order

(to be completed by a Licensed Provider: Physician, Dentist, Nurse Practitioner authorized by Ch. 94C)

*Student Name*________________________________ *Birth Date*______________

*Address*__________________________________ *Grade*________________

*Name of Licensed Prescriber*______________________ *Title*_______________

*Address*____

____

*Telephone#*____________________ *Emergency #*______________________

*Medication*___________________ *Route*___________________________

*Dosage*_______________________ *Frequency*________ *Time(s)*____________

*Action*____

____

(Please note: whenever possible, medication should be scheduled at times other than school hours.)

*Specific Instructions*____

____

*Date of Order*___________________ *Discontinue Date*____________________

*Diagnosis*____

*Significant Medical History*____

Optional Information

- *Special side effects, contraindications, or possible adverse reactions to be noted:*____
- ____
- *Other daily medications*____
- *Date of next scheduled visit to prescriber*___________________________
- *Consent of self-administration (provided the nurse determines it is safe and appropriate)* *Yes*_______ *No*_________

____ *Date*_______________

Signature of Licensed Prescriber