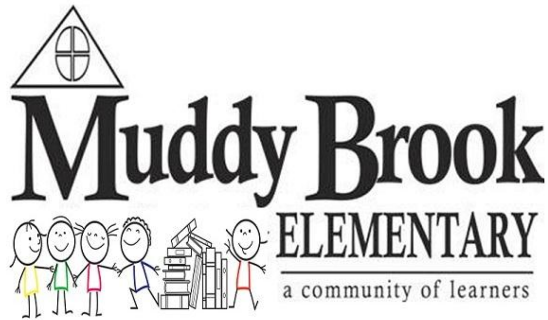

MEDICATION ORDER
(To be completed by a Licensed Prescriber)
Physician, Nurse Practitioner or others authorized by Chapter 94C
BERKSHIRE HILLS REGIONAL SCHOOL DISTRICT

Name of Student ________________________________Date of Birth_____________

Address ____Grade ______________

Name of Licensed Prescriber__________________________ Title _______________

Business Telephone Number__________Emergency Telephone Number___________

Medication____

Route of Administration ___________________________ Dosage _______________

Frequency ______________________Times of Administration___________________

(Please note: Whenever possible medications 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 ____

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 to prescriber: ________
4. Consent for self administration (provided the school nurse determines it is safe and appropriate.) Yes _______ No ________

____
(Signature of License Prescriber)