Medication Order Form to be Completed by Licensed Prescriber

Lincoln- Sudbury Regional High School
390 Lincoln Road
Sudbury, MA 01776
Health Office : 978-443-9961 x 2390
Fax # 978-639-3090

Name of Student: _____ DOB: _____

Address: _____ Grade: _____

Name of Liscensed Prescriber: _____

Business Number:_____ Emergency Number: _____

Medication: _____ Route: _____

Dosage: _____ Frequency: _____

Time (s) of Administration: _____
(Please note : When possible, medication should be scheduled at times other than school hours)

Specific directions or information for administration: _____

Date of Order: _____ Discontinuation Date: _____

Diagnosis: _____(If not in violation of confidentiality)

Any other Medical Conditions: _____

Optional Information

1. *Special side effects, contraindications or possible adverse reactions to be observed:*

_____

2. *Other medication taken by student:*

_____

3. *Date of 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 Licensed Prescriber *Date*

Reviewed- 10/13