ATTLEBORO PUBLIC SCHOOLS
Attleboro, MA

MEDICATION ORDER
(To be completed by a licensed prescriber)

Name of Student ____ Date of birth ______

Address ____ Grade _____
(street) (city/town)

Name of Licensed Prescriber ___________________________________ Title _________

Business Phone _______________________ Emergency Phone __________________

Medication ____

Route of administration _____________________ Dosage _____________________

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 condition(s)* ____

<u>Optional Information</u>

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

2.) Other medication 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 Licensed Prescriber

*if not in violation of confidentiality
MDPH , ASD revised 1/08