MEDICATION ORDER

(to be completed by a Licensed Prescriber:
Physician, Nurse Practitioner or other authorized by Chapter 94C)

Name of student_____ **Date of Birth** _____

Address:_____ **Grade/Class** _____
(street) **(city/town)**

Name of Licensed Prescriber_____ **Title**_____

Business Telephone Number_____ **Emergency Number**_____

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*** _____
** if not in violation of confidentiality*

Any other medical condition(s) _____

Optional information

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

_____

2. Other medication being taken by the student: _____

3. 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 _____ **Date** _____

This form may be mailed to: *(grades K-3)*
Solomon Schechter Day School
of Greater Boston
60 Stein Circle
Newton Centre, MA. 02459
Faxed to: 617-964-8693

(grades 4-8)
Solomon Schechter Day School
of Greater Boston
125 Wells Ave.
Newton Centre, MA. 02459
617-928-9108