Fairhaven Public Schools

Medication Order Form

(to be completed by a licensed prescriber)

Name of Student_____ Date of Birth_____

Address_____ Grade_____

City/State_____

Name of Licensed Prescriber_____Title_____

Business Phone_____ Emergency Phone_____

Medication_____

Dosage_____ **Route of administration**_____

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)*_____

_____

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 Yes____ No_____
   (provided the school nurse determines it is safe and appropriate)

_____ _____

Signature of Licensed Prescriber *Date*

* if not in violation of confidentiality