

BROCKTON PUBLIC SCHOOLS

Medication Order Form To Be Completed By Licensed Prescriber

Name of Student _____ Date of Birth _____

Address _____ Brockton, MA. 0230__ Grade ____ Room _____

Name of Licensed Prescriber _____ Tele. # (____) _____

Address _____

Medication _____ Dosage _____ Route _____

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)* _____

Optional Information

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

Date: _____

*** If not in violation of confidentiality.**