HINGHAM PUBLIC SCHOOLS
HINGHAM, MASSACHUSETTS

SCHOOL HEALTH SERVICES

Medication Order Form to be completed by a Licensed Prescriber

Name of Student_____Date of Birth_____

Address_____ Grade_____
(street) (city/town)

Name of Licensed Presciber_____Title_____

Business Telephone Number_____

Emergency Telephone 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*_____

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.