Saint John the Baptist Parish
19 Chestnut Street
Peabody, Massachusetts 01960
978/531-0444 FAX 978/531-3569

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 __________
(street) (city/town)

Name of licensed prescriber ________________________ Title _______________

Business phone __________________ Emergency phone___________________

Medication ____

Route of administration _______________________ Dosage _________________

Frequency _______ Time(s) of administration: by _________no later than________
(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 conditions *____

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 ____

* If not in violation of confidentiality