Fairhaven Public School

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

_____
Signature of Licensed Prescriber

* if not in violation of confidentiality.