MANSFIELD PUBLIC SCHOOLS HEALTH SERVICES
MEDICATION ORDER

(To be completed by a Licensed Prescriber:
Physician, Nurse Practitioner or others authorized by Chapter 94C)

Name of Student _____Date of Birth _____
Address _____ Grade _____
(Street) (City/town)

Name of Licensed Prescriber _____Title _____

Business Telephone #_____ Emergency Telephone #_____
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 medications being taken by the student: _____

3. The date of the next scheduled visit, or when advised to return to the prescriber: _____

4. Consent for self administration (provided the schools nurse determines that it is safe and appropriate).
YES _____ NO _____

* *if not in violation of confidentiality*

_____
Signature of Licensed Prescriber