



Medication Order Form

(to be completed by a licensed prescriber)

Pastor
Rev. Brian O'Toole

Principal
Donna Bresnahan

Student's Last Name: _____ First: _____ Middle Initial: _____ Male Female

Grade: _____ Date of Birth: _____

Mailing Address: _____

(primary) _____

Name of Licensed Prescriber: _____ Title: _____

Business Phone: (____) _____ Emergency Phone: (____) _____

Medication: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Times of Administration: _____

(N.B.: Whenever possible, medications should be scheduled for administration 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:

Special side effects, contraindications, or possible adverse reactions to be observed: _____

Other medication(s) being taken by the student: _____

Date of next scheduled visit or when advised to return to prescriber: _____

Consent for self-administration (with the concurrence of the school nurse): Yes No

Signature of Licensed Prescriber