

Sturgis Charter Public School



An International Baccalaureate Diploma School

MEDICATION ORDER

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

Name of Student _____ Date of Birth _____

Address _____ Grade _____

Name of Licensed Prescriber _____ Title _____

Business Telephone Number _____ Emergency Phone 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 * _____

And other medical condition(s)* _____

Optional Information

1. Specific 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 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*

