LYNN PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES
Prescriber Authorization for Medication Administration in Schools

MEDICATION ORDER FORM

Name of Student_____Date of Birth_____ Sex_____

Address_____ School_____ Gr/Rm #_____

****This section is to be completed by a Licensed Prescriber: Physician, Nurse Practitioner or other authorized by Chapter 94C****

Name of Licensed Prescriber_____ Title_____

Business Telephone # _____Emergency # _____

Medication _____ Route of Administration_____
(A separate form must be completed for each medication)

Dosage_____ Frequency_____ Time(s) of Administration_____
(Please note: Whenever possible, medication should be scheduled at times other than school hours)

Specific direction or information for medication administration:

_____

_____

Date of order_____ Discontinuation date_____

Diagnosis*_____ Any other medical condition(s)*_____

Allergies*_____

Optional Information

1. **Special side effects, contraindications, or possible adverse reactions to be observed:**

_____

2. **Other medication being taken by the student_____**

3. **The date of next scheduled visit or when advised to return to the 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**

Revised 2/2014
KMM