

**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**