

Por favor, lleve este formulario al doctor de su niño.

**LYNN PUBLIC SCHOOLS  
SCHOOL HEALTH SERVICES  
Medication Delivery 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**