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

Revised 8/2011

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