

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

LYNN PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Prescriber Authorization for Medication Administration in Schools

MEDICATION ORDER FORM

To be completed by a Licensed Prescriber: Physician, Nurse Practitioner or other authorized by Chapter 94C

Date of order _____ **Discontinuation date** _____

A new order is needed at the start of every school year

Name of Student _____ **Date of Birth** _____ **Sex** _____

Address _____ **School** _____ **Gr/Rm #** _____

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** _____

Whenever possible, medication should be scheduled at times other than school hours.

Specific direction or information for medication administration:

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

Allergies* _____

**If not a violation of confidentiality*

Optional Information:

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

Other medication being taken by the student _____

The date of next scheduled visit or when advised to return to the Prescriber: _____

Signature of Licensed Prescriber _____ **Date** _____