BISHOP STANG HIGH SCHOOL

A Nationally Recognized School of Excellence

PHYSICIAN MEDICATION ORDER

(to be completed by a Licensed Prescriber: Physician, Nurse Practitioner or others authorized by Chapter 94C)

Student's Name: _____ Gender: ____ D.O.B.: _____ Grade: ___
Address: _____ City: _____ State: __ Zip Code: _____
Name of Licensed Provider: _____
Business Phone: _____ Emergency Phone: _____

Name of Medication: _____
Route of Administration: _____ Dosage: _____
Time(s) of Administration: _____ Frequency: _____
Please note: Whenever possible, medications should be scheduled outside of school hours.
Specific directions or information for administration (i.e. specific signs and symptoms that warrant medication should be given immediately): _____
_____
_____
Date of Order: _____ Discontinue Date: _____
Diagnosis*: _____
Any other medical condition(s)*: _____
_____
Complete only if not in violation of confidentiality

Additional Information:

1. Specific side effects, contraindications, or possible adverse reactions to be observed:
   _____
   _____
2. Other medications being taken by this student: _____
   _____
3. Date of next scheduled visit or when advised to return to prescriber: _____
4. Consent to self-administer (if applicable and if the school nurse determines it safe and appropriate): YES NO

Licensed Provider Signature: _____ Date: _____