Avon Public Schools

MEDICATION ORDER

Must be completed by a licensed prescriber

(Physician, Nurse Practitioner or others authorized by Chapter 94C)

Student's Name _____Date of Birth _____Grade:_____

Name of prescriber:_____ Title:_____

(Please Print) (Please Print)

Phone:_____ Emergency Phone (if different):_____

Name of Medication(s):_____

Dose: _____ Route to be given:_____Time to be given:_____

Please identify the end date_____or this order will automatically expire at the end of the current school year.

Possible Side Effects/Contraindications:_____

Specific directions or information:_____

_____

Diagnosis and Pertinent Medical History:(if not in violation of confidentiality)

_____

Next Appointment:_____

May this child self-administer if the school nurse determines it is safe and appropriate?

Yes_____ No_____

Other medications being taken by the student:_____

Signature of Licensed Prescriber:_____Date:_____

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