Avon Public Schools

2016-2017
SCHOOL YEAR

Medication Order

Must be completed by a licensed prescriber
(Physician, Nurse Practitioner or others authorized by Chapter 94C)

Name of Student: ______________________________ Date of Birth: ____________

Grade: ________

Name of Prescriber: ____________________________ Title: ____________________
(Please print) (Please print)

Phone: ____________________ Emergency Phone (if different): ___________________

Name of Medication: ____

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 Effect/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.

FAX # 508-587-8447