

**Holten-Richmond Middle School**  
Office of the School Nurse  
55 Conant Street  
Danvers, Massachusetts 01923  
Phone 978-774-8590 ext. 3052 Fax 978-762-8332

**Medication Order**

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

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_  
(Street) (City/Town)

Name of Licensed Prescriber \_\_\_\_\_ Title \_\_\_\_\_

Business Telephone No. \_\_\_\_\_ Emergency Telephone No. \_\_\_\_\_

Medication \_\_\_\_\_

Route Of Administration \_\_\_\_\_ Dosage \_\_\_\_\_

Frequency \_\_\_\_\_ Time(s) of Administration \_\_\_\_\_  
*(Please note: Whenever possible, medication should be scheduled at times other than school hours).*

Specific directions or information for administration: \_\_\_\_\_

Date of Order \_\_\_\_\_ Discontinuation Date \_\_\_\_\_

Diagnosis\* \_\_\_\_\_

Any other medical condition(s)\* \_\_\_\_\_

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 the next scheduled visit or when advised to return to prescriber: \_\_\_\_\_

4. Consent for self-administration (provided the school nurse determines it is safe and appropriate) Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Signature of Licensed Prescriber

\* if not in violation of confidentiality