Danvers Public Schools
64 Cabot St.
Danvers, MA 01923

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