Hamilton-Wenham Regional School District
Medication Order Form to be completed by a Licensed Prescriber

Name of Student: _____ Date of Birth: _____

Address: _____Grade _____

Name of Licensed Prescriber: _____ Title: _____

Business Telephone Number: _____

Emergency Telephone Number: _____

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

Special side effects, contraindications, or possible adverse reactions to be observed _____

_____

Other medication being taken by the student: _____

_____

The date of the next scheduled visit or when advised to return to prescriber: _____

Consent for self administration (provided the school nurse determines it is safe and appropriate). Yes _____ No _____

_____ _____
(Signature of Licensed Prescriber) (Date)

* if not in violation of confidentiality