

Wellesley Public Schools
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 _____
(please print)

Phone Number _____ Emergency Number _____

Medication _____

Route of Administration _____ Dosage _____

Frequency _____ Times of Administration _____
(Please note: whenever possible, medication should be scheduled at times other than school hours.)

Specific direction 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 medications being taken by student: _____

3. Date of 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

