St. Paul School
18 Fearing Road
Hingham, MA 02043
781-749-2407
781-740-1262 Fax

Medication Order

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

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 Order_____

Diagnosis*_____

Any other medical conditions_____

Optional Information:

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

2) Other medications 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

Required for EACH medication and MUST be renewed each school year