

**WILLIAMSBURG SCHOOLS
PHYSICIAN'S MEDICATION ORDER**

This form should be completed in its entirety and signed by a Licensed Prescriber:
Physician, Nurse Practitioner or other person authorized by MGL Chapter 94 C.

Name of Student _____ **Date of Birth** _____

Address _____ **Grade** _____
(Street) (City) (State)

Name of Licensed Prescriber _____ **Title** _____

Business Telephone _____ **Emergency Number** _____

Address: _____

Office Where Child Is Seen: _____

Diagnosis: _____
(must be provided for medication to be administered)

Medication:
Name _____ **Dosage** _____ **Route** _____ **Time(s)** _____

Special directions or information for administration: _____

(Please note: Whenever possible, medication should be scheduled at times other than school hours.)

Discontinuation Date: School Year: YES ___ NO ___

Or specify other date: _____

(Please note: This order will be effective for one school year unless otherwise specified.)

Optional Information:

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

2.) The date of scheduled visit or when advised to return to Prescriber: _____

3.) Is supervised self-administration of medication approved, provided the school nurse determines it is safe and appropriate in the school setting and the parents agree?
(The student is monitored by staff while taking the medication, does not have access to other students' medications and the medication is stored in a locked cabinet at all times.) YES _____ NO _____

Signature of Licensed Prescriber

Date