DUXBURY 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:**

City/Town	**State/Zip**
Name of Licensed Prescriber	Title:
Business Telephone ☐	Emergency Telephone
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: (mm/dd/yyy)	Discontinuation Date: (mm/dd/yyy0
Diagnosis*	
Any other medication condition(s) *if not in violation of confidentiality*	

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