Attachment HA 4: Prescription Medication Order

Prescription Medication Order

(To be completed by a Licensed Physician, Nurse Practitioner or others authorized by Chapter 49C of MGL)

Name of Student: _____ Date of Birth: _____

Name of Prescribing Physician: _____

Business Telephone: _____Emergency Phone number: _____

1. Medication: _____Dosage: _____

Frequency: _____Time(s) of administration: _____

Specific directions or information for administration: _____

Date of Order: _____

Consent order for one year unless discontinuation date noted here: _____

Diagnosis for medication need*: _____

2. Medication: _____Dosage: _____

Frequency: _____Time(s) of administration: _____

Specific directions or information for administration: _____

Date of Order: _____

Consent order for one year unless discontinuation date noted here: _____

Diagnosis for medication need*: _____

3. Medication: _____Dosage: _____

Frequency: _____Time(s) of administration: _____

Specific directions or information for administration: _____

Date of Order: _____

Consent order for one year unless discontinuation date noted here: _____

Diagnosis for medication need*: _____

*** If not in violation of confidentiality**

Optional Information:

Side effects, contraindications or possible adverse reactions to be observed for:_____

_____

Signature of prescribing physician **Date**

*** Medication order expires one year from date signed unless otherwise stated.**