Weymouth Public Schools Health Services

Medication Order Form (to be completed by a licensed prescriber)

*****ALL MEDICATIONS AND ORDERS MUST BE DELIVERED DIRECTLY TO THE SCHOOL NURSE*****

Student Name:	Date of Birth:
Address:	Grade:

Provider Information

Licensed Provider:
Office Phone:
Office Fax:

Medication Order

Diagnosis*:	Other Medical Conditions*:
Medication:	Dosage:
Frequency:	Schedule:
Route of Administration:	**** Whenever possible, please schedule administration times outside of school hours*****
Date of Order:	Discontinue Date:
	**** All orders will discontinue on the last day of school unless otherwise noted****

* if not in violation of confidentiality

Additional Information

Possible side effects, contraindications, or adverse reactions:	
Any additional medications prescribed to the student:	
Consent for **Self Administration*** during school hours:	**YES**_____ **NO**_____

* Self-administration of medication at school (provided the school nurse determines it is safe and appropriate).

Signature of Licensed Provider: _____ **Date:**_____