Medication Order Form

To be completed by a Licensed Prescriber

Name of Student: ____ Date of Birth: __________________

Name of Licensed Prescriber: __________________________________ Phone #:_______________________

Medication: ______________________________ Route: ______ Dose: _________ Frequency:____________

Time 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 Date: _______________________________

Diagnosis: ____

Any other medical condition(s): ____

Signature of Licensed Prescriber:____

Date:_________________________________