**Westport Community Schools**
**Westport, MA 02790**

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_____
(street) (city/town)

Name of Licensed Prescriber______________________________ Title____________

Business Phone Number_________________ Emergency Phone Number___________

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____________________ Discontinuation Date___________________

Diagnosis*_____________________________________________________________

Any other medical condition(s)*__________________________________________

Consent for self administration (provided the school nurse determines it is safe and appropriate)
Yes_____ No_____
Consent for carrying own medication (inhaler or Epipen only). Yes _______ No_________.

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed:_________________________________________________________
2. Other medications being taken by the student:____________________________
_________________________________________________________________
3. The date of the next scheduled visit or when advised to return to prescriber:____________

____________________________________
Signature of Licensed Prescriber

*if not in violation of confidentiality
6/08