

**Office of the School Nurse  
Southbridge Public Schools  
Southbridge, Massachusetts**

**PHYSICIAN'S MEDICATION ORDER**

To be completed by a Licensed Prescriber: Physician, Nurse Practitioner, or other authorized by Chapter 94C

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City/Town)

Name of Licensed Prescriber \_\_\_\_\_ Title \_\_\_\_\_  
(Please Print)

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 \_\_\_\_\_ Discontinuation Date \_\_\_\_\_

Diagnosis\* \_\_\_\_\_

Any other medical condition(s)\* \_\_\_\_\_

**Optional Information**

1. Special side effects, contraindications, or possible adverse reactions to be observed: \_\_\_\_\_

2. Other medication being taken by the student: \_\_\_\_\_

3. Consent for self-administration (provided the school nurse determines it is safe and appropriate)

(YES) \_\_\_\_\_ (NO) \_\_\_\_\_

\_\_\_\_\_  
**Signature of Licensed Prescriber**

\*Not in violation of confidentiality