

St. Paul School  
18 Fearing Road  
Hingham, MA 02043  
781-749-2407  
781-740-1262 Fax

### Medication Order

(To be completed by a Licensed Prescriber: Physician, Nurse Practitioner or others authorized by Charter 94C )

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_

Name of Licensed Prescriber \_\_\_\_\_ Title \_\_\_\_\_

Business Telephone Number \_\_\_\_\_

Emergency Telephone 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 \_\_\_\_\_

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Date of Order: \_\_\_\_\_ Discontinuation Order \_\_\_\_\_

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

Any other medical conditions \_\_\_\_\_

#### Optional Information:

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

2) Other medications taken by the student \_\_\_\_\_

3) The date of the next scheduled visit or when advised to return to prescriber \_\_\_\_\_

4) Consent for self administration (provided the school nurse determines it is safe and appropriate) Yes \_\_\_\_\_ No \_\_\_\_\_

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

Required for EACH medication and MUST be renewed each school year