The City of Lowell • Health Department
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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_____

Name of Licensed Prescriber_____ Title_____

Business Telephone #_____ Emergency Telephone #_____

Medication_____

Route of Administration_____ **Dosage**_____

Frequency_____ **Time(s) of Administration**_____
Please note: When possible, medication should be scheduled at times other than school hours.

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

Specific directions or information for administration:_____

Date of Order:_____ Discontinuation Date:_____

Diagnosis_____

Any other medical condition(s)_____

Special side effects, contraindications, or possible adverse reactions to be observed:

_____

Other medication being taken by student:_____

The date of the next scheduled visit or when advised to return to prescriber:_____

_____
Signature of Licensed Prescriber