LEICESTER PUBLIC SCHOOLS
PHYSICIANS MEDICATION ORDER

Name of Student _____Date of Birth_____
Address_____Grade_____
(Street) (Town)

Name of Licensed Prescriber_____Title_____

Business Telephone Number_____
Emergency Telephone Number_____

Medication_____

Route of Administration_____Dosage_____
Frequency_____Time of Administration_____
(Please note: Whenever possible, medication should be scheduled at times other than school hours and ONLY ONE DOSE of each medication will be given per day.)

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. 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

*if not in violation of confidentiality