HAVERHILL PUBLIC SCHOOLS HEALTH SERVICES
LICENSED PROVIDER MEDICATION ORDER FORM

TO BE COMPLETED BY A LICENSED PRESCRIBER PHYSICIAN, NP, OR OTHER AUTHORIZED BY CHAPTER 94C

I, the undersigned licensed provider, request that the school nurse or other designated person administer the medication I have prescribed below. I certify that failure to administer the medication may jeopardize the health of my patient.

Name of Student: _____ Date of Birth: _____

Address: _____

Name of Licensed Prescriber: _____ Title: _____

Business Phone: _____ Address: _____

Diagnosis*_____

Any other medical condition(s)* _____

Medication _____ **Dose** _____

Route _____ **Frequency** _____ **Time** _____

Date Ordered _____ **Discontinuation Date** _____

Specific directions _____

Potential Side effects _____

(Please note: Whenever possible, medication should be scheduled at times other than school hours).

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: _____ Date: _____

School Nurse Signature: _____Date: _____