Frontier Regional and Union #38 School Districts / Conway, Deerfield, Sunderland, & Whately
PRESCRIPTION MEDICATION FORM

Medication Order Form to be completed by Licensed Prescriber:

Student Name: _____ Date of Birth: _____

ALLERGIES: _____

Name of Licensed Prescriber: _____ Phone: _____

Name of Medication: _____

Dosage: _____ Route of Administration: _____

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 (for which medication is prescribed)*: _____

Any other relevant medical condition(s)*: _____

Side Effects, contraindications or possible adverse reactions: _____

_____

Other medication being taken by the student: _____

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

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

_____ _____
Signature of Licensed Prescriber Date

**If not in violation of confidentiality.*