PRESCRIPTION MEDICATION ORDER
Middlesex School

To be completed by Licensed Prescriber: Physician, Nurse Practitioner, or others authorized by Massachusetts General Laws, Chapter 94C. ***Please photocopy form for additional prescriptions.***

Name of Student: ___________________________________Date of Birth:_______________________

Address: ____ Grade: _______________________

Name of licensed prescriber: ____

Address of prescriber____

Business Telephone: ___________________________ Fax Number: ____________________________

Diagnosis: ____

Other medical conditions:____

MEDICATION:

Name:_____________________________________ Strength: ____________________________

Dosage: ______________Frequency: ____________ Route of Admin: _____________________

Specific instruction/information for administration: ______________________________________

Date of order: ______________________ Discontinuation date: ____________________________

Side effects, contraindications, possible adverse reactions to be observed for:________________________

Changes made to other medications:____

Other medications being taken by student:____

Date of next scheduled visit/advised return by prescriber: _______________________________________

Consent for self-administration [provided the Health Center deems appropriate] ( ) Yes ( ) No

Signature of Licensed Prescriber: ____

Please photocopy for additional prescriptions

Cruz Health Center, Middlesex School 1400 Lowell Road Concord, MA 01742

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See Medication PolicyForm

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