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 Policy