COMPASS School

Dorchester, Massachusetts

LICENSED PRESCRIBED MEDICATION ORDER FORM

(To be completed by a Licensed Prescriber:
Physician, Nurse Practitioner, or others authorized by Chapter 94C)

Name of Student _____ **Date of Birth** _____

Street Address _____ **Grade** _____

City/Town _____

Business Phone Number _____

Emergency Phone Number _____

Medication _____

Route of Administration _____ **Dosage** _____

Frequency _____ **Time(s) of Administration** _____

Specific directions or information for Administration _____

_____

Date of Order _____ **Discontinuation Date** _____

Diagnosis* _____

Any other medical condition(s)* _____

Additional Information

Specific side effects, contraindications, or possible adverse reactions to be observed: _____

_____

***Other medications being taken by the student:** _____

_____

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

_____

Consent for the self-administration if the medication ordered is an inhaler for asthma or Epinephrine for an allergic reaction. (Provided the school nurse determines it is safe and appropriate.) ☐ **Yes** ☐ **No**

Signature of Licensed Prescriber: _____

*If not in violation of confidentiality

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