GROTON-DUNSTABLE REGIONAL SCHOOL DISTRICT

LICENSED PRESCRIBER MEDICATION ORDER FORM

Student Name: _____	**DOB: _____**

SECTION 1 – PRESCRIBER INFORMATION

1. Licensed Prescriber's Name: _____

2. Title: ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other:_____

3. Business Phone: _____ Fax: _____

SECTION 2 – MEDICATION INFORMATION

Whenever possible, please try to scheduled medication at times other than school hours.

1. Child's Diagnosis: _____

2. Medication Name: _____

3. Dose: _____ Frequency: _____

3. Route: ☐ PO ☐ Inhaled ☐ IM ☐ SC ☐ Other: _____

4. Additional directions or instructions for administration:_____
   _____
   _____

5. Side effects, contraindications, or possible adverse reactions school staff should be aware of and observe for (please list): _____
   _____
   _____

6. Start Date: _____ End Date: _____

7. Other medication student is taking: _____
   _____

8. Any other medical concerns: _____
   _____

8. Date of next scheduled visit or when advised to return for follow up: _____

9. Can student self-administer this medication (if school nurse determines it is safe and appropriate):
   ☐ Yes ☐ No

**** PLEASE NOTE: STUDENTS ARE NOT ALLOWED TO SELF-ADMINISTER CONTROLLED SUBSTANCES (I.E. RITALIN, ETC.)****

Date: _____	**Prescriber's Signature: _____**

Please return this form to: School Nurse