Scituate Public Schools
Provider Medication Order

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

Name of Student: _____ Date of Birth_____

Address of Student: _____

City/Town: _____Grade: _____

Name of Prescribed Medication: _____

Route of Administration: _____Dosage: _____

Frequency: _____ Time (s} of Administration: _____

Specific directions or information for administration:

_____

Date of Order: _____ Discontinuation Date: _____

Diagnosis/Medical Condition (s}*_____

Permission to withhold on field trips, early releases, late starts, if parent requests: Yes_____ No _____

Additional Information:

1. Specific side effects, contraindications, or adverse reactions to be observed:

_____

2. Other medications being taken by student*: _____

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

4. Consent for self-administration for medication (with parent permission and provided the school nurse determines it is safe and appropriate.) Yes _____ No _____

Name and Title of Licensed Prescriber_____

Business and Emergency Phone Numbers: _____

Signature of Licensed Prescriber: _____Date_____

Please submit completed form to the school nurse at the child's school.

****If not in violation of confidentiality***