Barnstable Public Schools

Physician Medication Order

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

Student's name _____ Date of Birth _____

Name of Licensed Prescriber _____ Title _____

Business telephone number _____Emergency # _____

Medication: _____

Route of administration _____ Dosage _____

Frequency _____ Time of administration _____
(Please Note: Whenever possible, medication should be scheduled at times other than school hours.)

Specific directions or information for administration _____
_____

Date of Order _____ Discontinuation Date _____

Diagnosis* _____

Any other medical conditions * _____
_____

Optional Information

1. **special side effects, contraindications, or possible adverse reactions**
   _____
2. **Other medications being taken by the student _____**
   _____
3. **The date of the next scheduled visit or when advised to return _____**
   _____
4. **Consent for self administration (provided the school nurse determines it is safe and appropriate) Yes ____ No ____**

_____
Signature of Licensed Prescriber Date

***if not in violation of confidentiality**