Medication Order For Prescribed Medications

To be completed by a Physician, Nurse Practitioner or other authorized position for any medications (prescription AND over-the-counter) needed by the patient.

Please make as many copies of this form as needed (one per prescription/medicine.)

To be completed by a Licensed Prescriber: Physician, Nurse Practitioner or other authorized person

---

Student Name: ____ Date of Birth: ____/____/____

Street Address: ____Grade: ____________

City: ____State: ________________ Zip: _______________________

Medication: ____

Route of Administration: ____ Dosage: _______________________

Frequency: ________________________________ Time(s) of Administration: __________________________________

Diagnosis Requiring Medication: ____

Specific directions or information for administration: ____

____

The date of the next scheduled visit or when advised to return to the prescriber: ________________________________

Consent for self-administration: ____ Yes ____ No

Date of order: ____ Discontinuation Date: _________________________

Name of Licensed Prescriber (print): ____

Business Telephone: _____________________________________ Emergency Telephone: ________________________

Signature: ____ Date: _____________________