

**HADLEY SCHOOL DEPARTMENT
MEDICATION ORDER**

This form should be completed in its entirety and signed by a Licensed Prescriber:
Physician, Nurse Practitioner or other person authorized by MGL Chapter 94 C.

Name of Student _____ Date of Birth _____

Address _____ Grade _____
Street City State

Name of Licensed Prescriber _____ Title _____
Business Telephone _____ Emergency Number _____

Medication

Name _____ Dosage _____ Route _____ Time(s) _____

Special directions or information for administration: _____

Please note: Whenever possible, medication should be scheduled at times other than school hours.

Discontinuation Date: School Year including Summer Program: YES ____ NO ____
Specify other date: _____

(Please note: This order will be effective for one year unless otherwise specified.)

Diagnosis (*If not in violation of confidentiality) _____

Optional Information

1.) Special side effects, contraindications, or possible adverse reactions to be observed:

2.) The date of scheduled visit or when advised to return to Prescriber: _____

3.) Is supervised self-administration of medication approved, provided the school nurse determines it is safe and appropriate in the school setting and the parents agree?
(The student is monitored by staff while taking the medication, does not have access to other students' medications and the medication is stored in a locked cabinet at all times.) YES _____ NO _____

Signature of Licensed Prescriber

Date