

**Hamilton-Wenham Regional School District**  
**Medication Order Form to be completed by a Licensed Prescriber**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Grade \_\_\_\_\_

Name of Licensed Prescriber: \_\_\_\_\_ Title: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_

Emergency Telephone Number: \_\_\_\_\_

Medication \_\_\_\_\_

Route of Administration: \_\_\_\_\_ Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_ Time(s) 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 condition(s)\* \_\_\_\_\_

Optional Information

Special side effects, contraindications, or possible adverse reactions to be observed \_\_\_\_\_

Other medication being taken by the student: \_\_\_\_\_

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

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