White Oak SCHOOL
533 North Road
Westfield, MA 01085
(413) 562-9500

# MEDICATION ORDER

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

**Student** ______________________________ **Date of Birth** ____________________

Address ______________________________________________________________

**Medication** ________________________ **Dosage** __________________________

**Route of Administration** ________________ **Frequency** _____________________

**Condition for which drug is being administered** ______________________________

**Time(s) to be administered at school** ___________________________________

For allergic reaction, please specify specific symptoms for medication to be given____________
______________________________________________________________________

Side effects, contraindications, or possible adverse reactions_______________________
______________________________________________________________________

Any other medical condition(s)* ______________________________________________

**Date of Order** ____________________ **Discontinuation Date** ____________________

**Name of Licensed Provider** _________________________________________________

**Signature of Licensed Prescriber** ____________________________________________

<u>Optional Information</u>

1. Other medication being taken by the student_______________________________ _
   ___________________________________________________________________
2. Date of the next scheduled visit or when advised to return to prescriber:_______________
3. Consent for self-administration, provided the school nurse determines it is safe and appropriate.
   Yes ___ No ___ ___

*if not in violation of confidentiality

Revised 6/2016