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

2023-2024

MEDICATION ORDER

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

Student _____ **Date of Birth** _____

Medication _____ **Dosage** _____

Route of Administration _____ **Frequency** _____

Time(s) to be administered at school _____

Condition for which drug is being administered _____

For treatment for allergic reaction, please specify specific symptoms:

_____

Medication side effects, contraindications, or possible adverse reactions:

_____

Consent for self-administration, provided the school nurse determines it is safe and appropriate: **Yes _____ No _____**

Date of Order _____ **Discontinuation Date** _____

Name of Licensed Provider _____

Signature of Licensed Prescriber _____

Optional Information

1. Any other medical condition(s)*

_____

2. Other medication being taken by the student:

_____

3. Date of the next scheduled visit or when advised to return to prescriber:

_____

*if not in violation of confidentiality

Revised 6/2023