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

2024-2025

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 _____________________________________

<u>Optional Information</u>

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