

GLEN URQUHART SCHOOL
74 HART ST.
BEVERLY, MA 01915
Phone: 978-927-1064 (x176 for nurse)
Fax: 978-927-1015

State Required Medication Order

(to be completed by a licensed prescriber)

Name of Student _____ Date of Birth _____

Address _____ Grade _____

(street, town, zip)

Name of Licensed Provider _____ Title _____

Phone # _____ Fax # _____

Food/Drug Allergies (please be specific) _____

PRESCRIPTION MEDICATION

Medication _____ Dosage _____

Route of administration _____ 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) * _____

OVER -THE-COUNTER-MEDICATIONS (PRN)

Tylenol (children's/adult) Dosage _____ Frequency _____
(circle)

Advil (children's/adult) Dosage _____ Frequency _____
(circle)

Benadryl (children's/adult) Dosage _____ Frequency _____
(circle)

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

2. Other medication being taken by the student: _____

3. The date of the next scheduled visit or when advised to return to prescriber: _____

4. Consent for self administration (provided the school nurse determines it is safe and appropriate).

Yes _____ No _____

(signature of licensed prescriber)

Date: _____

(date)

* if not in violation of confidentiality.