BRISTOL COUNTY AGRICULTURAL HIGH SCHOOL
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School Nurse
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MEDICATION ORDER FORM

(To be completed by a Licensed Prescriber-Physician, or Nurse Practitioner)

Name of Student:_____ Date of Birth:_____

Address:_____ Grade:_____
Name of Licensed Prescriber:_____ Title:_____

Business Telephone Number:_____

Emergency Telephone Numbe:r_____

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:_____ Discontinue Date:_____

Diagnosis:_____

Any other medical condition(s):_____

Optional Information

1. **Special side effects, contraindications, or possible adverse reactions to be observed:_____**
2. **Other medication(s) 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 an appropriate) Yes:_____ No:_____**

_____ _____

Signature of Licensed Prescriber **Date**