Bedford Public Schools School Year_____

Medication Order

(To be completed by a licensed prescriber:
Physician, Nurse Practitioner or others)

Name of Student _____ Date of Birth_____

Address_____Grade_____

Name of Licensed Prescriber _____Telephone _____

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 _____ Discontinuation Date_____

Diagnosis*_____

Any other medical condition(s)*_____

Optional Information:

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

*If not in violation of confidentiality

_____ _____
Signature of Licensed Prescriber Date