

# MAYNARD

## PUBLIC SCHOOLS

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### HEALTH SERVICES DEPARTMENT

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### MEDICATION ORDER

To be completed by a licensed Prescriber: Physician, Nurse Practitioner  
or others authorized by Chapter 94C.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date of Order: \_\_\_\_\_ Discontinuation Date: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Frequency: \_\_\_\_\_ Time to be given at school: \_\_\_\_\_

**PLEASE NOTE:** Medication should be scheduled at times other than school hours  
whenever possible.

Known Allergies: \_\_\_\_\_

Any other medical conditions: \_\_\_\_\_

Specific directions or information for administration: \_\_\_\_\_

### OPTIONAL INFORMATION

1. Special side effects, contraindications, or possible adverse reactions to be observed: \_\_\_\_\_
2. Other medications being taken by student: \_\_\_\_\_
3. Date of 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

Name of Licensed Prescriber: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Signature of Licensed Prescriber: \_\_\_\_\_

Date: \_\_\_\_\_