LANDMARK SCHOOL

Medication Order Form

(to be completed by a Licensed Prescriber)

Name of Student:_____ Date of Birth:_____

Name of Licensed Prescriber and Title:_____

Prescriber Business Phone:_____

Prescriber Emergency Phone:_____

Medication:_____Dosage:_____

Frequency:_____Time(s) of Administration:_____

Date of Order:_____Discontinuation Date:_____

Diagnosis* and reason for giving medication: _____

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

_____*(Signature of Licensed Prescriber)*

* if not in violation of confidentiality