

**STOUGHTON PUBLIC SCHOOL  
STOUGHTON, MASSACHUSETTS**

**MEDICATION ORDER**

(to be completed by a Licensed Prescriber, Physician,  
Nurse Practitioner or others authorized by Chapter 94C)

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

Address: \_\_\_\_\_ Grade: \_\_\_\_\_  
(street) (city/town)

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

Business Telephone No.: \_\_\_\_\_ Emergency Telephone No.: \_\_\_\_\_

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 \_\_\_\_\_

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