SOUTH SHORE REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL
SCHOOL HEALTH SERVICES

LICENSED PRESCRIBER
MEDICATION ORDER FORM

Name of Student_____ Date of Birth_____

Name of Prescriber_____ Phone_____

Medication_____ Diagnosis*_____

Dosage_____ Route_____ Frequency_____ Time of Day_____

Date of Order_____ Discontinuation Date_____

Intended effect of this medication_____
_____

Any other medical conditions*_____

Other medication being taken by the student*_____

Consent for self-administration (provided the nurse determines it is safe and the parent is in agreement). ☐ YES ☐ NO

Signature of Prescriber_____ Date_____

Medication cannot be transported to school by the student and <u>will be destroyed</u> if it is not picked up within one week following termination of the order or <u>by the last day of the school year</u>.

**if not in violation of confidentiality*