

**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 will be destroyed if it is not picked up within one week following termination of the order or by the last day of the school year.

**if not in violation of confidentiality*