WAYLAND SCHOOL COMMUNITY PROGRAMS

MEDICATION ADMINISTRATION ORDER

To be Completed by a Licensed Healthcare Provider

Name of Student: _____DOB:_____

Diagnosis:_____

Food/Drug Allergies:_____

Other medication(s) being taken by the student:_____

Name of Medication:_____

Dosage:_____

Time(s) to be administered at after school program:_____

Route of Administration:_____

Possible Side Effect/Adverse Reactions/Contraindications: _____

Start Date of Order:_____ End Date of Order:_____

Permission for Self-Administration and Self-Carry:

Self-administer: Yes_____ No_____ Self-carry: Yes_____ No_____

Nurse will discuss with the student and family and determine if permission is appropriate in the WSCP AFTER SCHOOL PROGRAMS / SUMMER PROGRAMS setting.

_____ _____

Physician/Licensed Provider Signature (including credentials) **Date**

_____ _____

Physician/Licensed Provider Printed Name Phone Number

_____ _____

Address Fax Number