St. Stanislaus School

MEDICATION ORDER

To be completed by a Licensed Prescriber

Student's Name: _____ **Date of Birth:** _____

Diagnosis: * _____

Medication: _____

Route of Administration: _____ **Dosage:** _____

Time (s) of Administration: _____

(Please note: Whenever possible, medication should be scheduled at times other than school hours.)

Duration of Treatment: _____

Special side effects, contraindications or possible adverse reactions to be observed

_____

_____

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

Yes _____ **No** _____

_____
Signature of Licensed Provider

Date of order: _____
Discontinuation date: _____
Address of Provider: _____

***if not in violation of confidentiality**

Should a change in any of the above information occur, a revised written physician's statement must be submitted

534 Front Street, Chicopee, MA 01013
Tel.(413)592-5135*Fax(413)598-0187*e-mail ststanis@st.stanislaus.mec.edu
website www.st.stanislaus.mec.edu