



Hampstead Academy

Medication Order (to be completed by a licensed Provider)

Name of Student: _____

Address: _____

(Street)

(City/Town)

(State)

(Zip)

Date of Birth: _____ Grade: _____

Name of Licensed Prescriber: _____

Title: _____

Business Telephone: _____ Emergency Telephone: _____

Medication: _____

Route of Administration: _____ Dosage: _____

Specific directions or information for administration: _____

Date of Order: _____ Discontinuation Date: _____

Diagnosis: _____

Any other medical condition: _____

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 appointment (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 Professional: _____

Date: _____