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: _____