

*St. James St. John School*

*180 Orchard Street  
New Bedford, MA 02740  
Telephone (508) 996-0534*

**Medication Order Form**

(to be completed by a licensed prescriber)

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_  
(street) (city/town)

Name of Licensed Prescriber \_\_\_\_\_ Title \_\_\_\_\_

Business Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Medication \_\_\_\_\_

Route of administration \_\_\_\_\_ Dosage \_\_\_\_\_

Frequency \_\_\_\_\_ Time(s) of Administration \_\_\_\_\_

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

Specific directions or information for administration: \_\_\_\_\_

Date of Order \_\_\_\_\_ Discontinuation Date \_\_\_\_\_

Diagnosis\* \_\_\_\_\_

Any other medical condition(s)\* \_\_\_\_\_

Additional 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 scheduled visit 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 Prescriber

\* if not in violation of confidentiality.