SHREWSBURY PUBLIC SCHOOLS
MEDICATION ORDER

PART A: To be filled out by Licensed Prescriber

Name of Student:_____ Date of Birth:_____

Office Telephone Number:_____

Name of Medication:_____

Route:_____ Dose:_____

Frequency:_____ Time:_____

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: _____

   _____

Signature of Licensed Prescriber: _____

Part B: To be filled out by Parent/Guardian

1. I give permission for the school nurse to administer medication as per this medication order.
   YES_____ NO_____

2. I give permission for the school nurse to instruct a trained, responsible adult in administering the above – mentioned medication to my child on field trips.
   YES_____ NO_____

3. I consent that my student may carry ***emergency*** medication at school (i.e. EpiPen, inhaler, insulin).
   YES_____ NO_____

Parent/Guardian Signature: _____ Daytime Phone: _____