WAYLAND PUBLIC SCHOOLS

MEDICATION ORDER FORM
TO BE COMPLETED BY LICENSED PRESCRIBER & PARENT
(One prescription medication per form)

Student's Name:	**Date of Birth:**	**Sex:**
Address:		
(Street)	**(City/Town)**	**Grade:**
Pertinent Medical Condition(s):		
Allergies:		
Name of Licensed Prescriber:		**Title:**
Telephone Number:		
Consent for Self Administration (Inhalers only) yes no		
(*Provided school nurse deems it safe and appropriate)*		
Administration of Prescription/Other Over the Counter Medication:		
(Name of medication)		
Dosage:	**Route of Administration:**	
Frequency:	**Time(s) of Administration:**	

Other medication taken by the student:

I give permission for the School Nurse to administer the above medication to this student.

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

Licensed Prescriber's Signature:	**Date:**
Parent's Signature:	**Date:**

Please return the completed form to the attention of the School Nurse at your child's school.

Fax # available on each school web page