

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