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