BELMONT PUBLIC SCHOOLS

Medication Order Form to be completed by a licensed prescriber

Name of Student_______________________________________Date of Birth_________
Address____ Grade ________

Name of Licensed Prescriber _________________________________ Title ___________
Business Telephone Number _______________________________________
Emergency Telephone Number _____________________________________
Medication ____
Route of Administration ________________________________Dosage _____________
Frequency ____________________________ Times(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)* ____

Optional Information

1. Side effects, contraindications, or possible adverse reactions: ________________
   ____
2. Other medications being taken by the student: _____________________________
   ____
3. 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 Date

* if not in violation of confidentiality
** For more detailed information regarding the Belmont Public Schools, Medication Administration Policy, please see refer to the BPS Health and Nursing Services website.

Revised:12.17