FOXBOROUGH PUBLIC SCHOOLS
School Health Services
FOXBOROUGH HIGH SCHOOL
(508) 543-1630 FAX (508) 543-1679

Medication Order to be Completed by a Licensed Prescriber

(This form will only support ONE medication per page. Please feel free to make copies!!!)

Student's Name: _____ **D.O.B.** _____

Address: _____ **Grade:** _____

Name and title of the licensed prescriber (Please print): _____

Business telephone #: _____ **Fax #:** _____

Emergency telephone #: _____

Medication: _____ **Dosage:** _____

Route: _____ **Frequency:** _____ **Time 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 Order:** _____

Diagnosis: _____

Consent for self-administration, providing school nurse determines it is safe and appropriate:
Yes _____ No _____

May this medication be held on field trip days with parental consent: Yes _____ No _____

Any other medical conditions: _____

Optional Information:

1. Side effects, contraindications, or possible adverse reactions to be observed: _____
   _____
2. Other medications taken by the student: _____

Signature of Licensed Prescriber: _____

Date: _____