

HAVERHILL PUBLIC SCHOOLS - HEALTH SERVICES LICENSED PROVIDER MEDICATION ORDER FORM

TO BE COMPLETED BY A LICENSED PRESCRIBER PHYSICIAN, NP, OR OTHER AUTHORIZED BY CHAPTER 94C

I, the undersigned licensed provider, request that the school nurse or other designated person administer the medication I have prescribed below. I certify that failure to administer the medication may jeopardize the health of my patient.

Address:	Name of Student:			Date of Birth:	
Business Phone:	Addres	ss:			
Diagnosis* ICD-10 Code* Any other medical condition(s)* Medication Dose Route Frequency Time Date Ordered Date Ordered Discontinuation Date Route Specific directions Potential Side effects (Please note: Whenever possible, medication should be scheduled at times other than school hours). Diagnosis* Any other medical condition(s)* Optional Information: 1. Special side effects, contraindications, or possible adverse reactions to be observed: 2. Other medication being taken by the student: 3. The 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).	Name	of Licensed Prescribe	::	Title:	
Any other medical condition(s)* Medication Dose Route Date Ordered Discontinuation Date Route Specific directions Potential Side effects (Please note: Whenever possible, medication should be scheduled at times other than school hours). Diagnosis* Any other medical condition(s)* Optional Information: 1. Special side effects, contraindications, or possible adverse reactions to be observed: 2. Other medication being taken by the student: 3. The 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).	Busine	ess Phone:	Address:		
Medication	Diagnosis*			ICD-10 Code*	
Route	Any ot	her medical conditior	(s)*		
Date Ordered Discontinuation Date Route Specific directions Potential Side effects (Please note: Whenever possible, medication should be scheduled at times other than school hours). Diagnosis* Any other medical condition(s)* Optional Information: 1. Special side effects, contraindications, or possible adverse reactions to be observed: 2. Other medication being taken by the student:	Medication		Dose		
Specific directions	Route		Frequency	Time	
Potential Side effects	Date	Ordered	Discontinuation Date	Route	
Potential Side effects	Spec	ific directions			
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Signature of Licensed Prescriber: Date:	Signati	ure of Licensed Press	iber:	Date	

School Nurse Signature: ______Date: _____Date: ______Date: ______Date: _____Date: _____Date: _____Date: ______Date: ______Date: ______Date: ______Date: ______Date: _____Date: ______Date: _____Date: _____Date: ______Date: _____Date: _____Date: _____Date: _____Date: _____Date: _____Date: _____Date: _____Date: _____Date: ______Date: _____Date: _____Date: _____Date: ______Date: _____Date: ______Date: ______Date: _____Date: ______Date: ______Date: ______Date: ______Date: ______Date: ______Date: ______Date: ______Date: ______Date: _____Date: _____Date: _____Date: _____Date: ______Dat