VENERINI ACADEMY
27 Edward Street, Worcester, MA 01605/ Tel. 508-753-3210/ Fax 508-754-6050

Medication Order Form

Name of Student_____ Date of Birth _____

Address_____ Grade _____

Name of Licensed Prescriber_____ Title_____

Business Phone_____ Emergency Phone_____

Medication_____

Route of administration_____ Dosage_____

Frequency_____ Time(s) of Administration_____

Date of Order_____ Discontinuation Date_____

Diagnosis*_____

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). Yes_____ No_____

_____ _____

Signature of licensed prescriber **Date**