WAYLAND PUBLIC SCHOOLS

MEDICATION ORDER FORM
TO BE COMPLETED BY LICENSED PRESCRIBER & PARENT

Student's Name:_____ **Date of Birth:**_____ **Sex:**_____
Address:_____ Grade:_____
(street) (city/town)
Pertinent Medical Condition(s)_____
Allergies_____

Name of Licensed Prescriber:_____ **Title:**_____
Telephone Number:_____ Date of order:_____

Consent for Self Administration (Inhalers only) yes no
(Provided school nurse deems it safe and appropriate)

Administration of Prescription Medication:_____
(one prescription medication per form) (name of medication)
Dosage:_____ Route of Administration:_____
Frequency:_____ Time(s) of Administration:_____
Specific directions or information for Administration:_____

Administration of Non-prescription (over the counter) Medication(s):
Acetaminophen: Dose_____ Route_____ Frequency_____ Specific Directions_____
Ibuprofen: Dose_____ Route_____ Frequency_____ Specific Directions_____
Antacid: Dose_____ Route_____ Frequency_____ Specific Directions_____

Other medication taken by the student:_____

I give permission for the School Nurse to administer the above medication(s) 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