Martha's Vineyard Regional High School

Health Office
PO Box 1385 Oak Bluffs, MA 02557
Phone (508) 693-1033 Fax (508) 696-6042

MEDICATION ORDER

Name:_____Date of Birth: _____ Grade: _____

Current Medications*:_____

Food or drug Allergies*:_____

Name of Physician:_____ Phone:_____

To Be FIlled Out by Prescribing Physician

Diagnosis*:_____

Medication:_____***Dosage:***_____

Route of Administration_____***Frequency:***_____

Date of Order:_____***Discontinuation Date:***_____

Next scheduled visit or when advised to return to prescriber:_____

Any other medical condition(s)*_____

Side effects, contraindication, or possible adverse reactions to be observed:

_____

Signature of Physician **Date**

I consent to have the school nurse share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

_____

Signature of Parent/Guardian Date
Mother___Father___Other_____Phone:_____

_____

Signature of School Nurse Date

* If not in violation with confidentiality