BISHOP CONNOLLY HIGH SCHOOL
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PRESCRIBER MEDICATION ORDER FORM

to be completed by a Licensed Prescriber

Name of Student _____ Date of Birth _____

Address _____ Grade _____
(Street) (City/Town)

Name of Licensed Prescriber _____ Title _____

Business Telephone #_____

Medication Name _____ Diagnosis*_____

Route of Administration _____ Dosage _____

Frequency _____ Time(s) of Administration _____

Please note: Whenever possible, medication should be scheduled at times other than school hours.

Any Special Instructions for Administration _____

_____

Date of Order _____ Date of Discontinuance _____

Any other medical condition(s) to be aware of?*_____

_____

Special side effects, contraindications, or possible adverse reactions to be observed _____

_____

Other medication being taken by the student*_____

_____

Consent for self-administration (provided the school nurse determines it is safe) ☐ Yes ☐ No

_____ _____
Signature of Licensed Prescriber Date

**If not in violation of confidentiality*