**BISHOP CONNOLLY HIGH SCHOOL**
373 Elsbree Street, Fall River, MA 02720
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www.bishopconnolly.com

**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)