Northeast Metro Tech High School
Telephone: 781-246-0810, ext 1624/1620 - Fax: (781) 246-9323

Medication Order for Physician and Parent

PHYSICIAN'S ORDER:

Name of Student: _____ DOB: _____

Medication: _____ Dosage: _____

Route of administration _____

Frequency_____ Time(s) of administration _____

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

Diagnosis: (if not confidential) _____

Specific directions/instructions for administration: _____

_____

Date of Order _____ Discontinuation Date _____

_____
Physician's/Licensed Prescriber Signature Date

_____
Address Telephone

TO BE COMPLETED BY PARENT /GUARDIAN:

Student's Name: (print) _____Grade: _____

Parent/Guardian Telephone Number (s): Home _____ Cell/Work _____

1. I give permission for the school nurse or designee to administer the above medication prescribed.
2. This medication is being taken for: _____
3. List any other medications your child takes: _____
   _____
4. Physician's Name (please print):_____
5. I give permission to the school nurse to inform appropriate school personnel relative to the prescribed medicine administered to my child: ____Yes _____ No

Please note: I understand that I may retrieve the medication from the school nurse at any time and that the medication will be destroyed if it is not picked up within one week following the termination of the order.

Signature of parent/guardian: _____ Date: _____