JHCD-F2

Ipswich Public Schools

Medication Order

(completed by licensed prescriber - please return to the School Health Room)

Student _____ Date of Birth _____

Address _____ Grade _____

Licensed Prescriber_____Title _____

Address _____

Phone_____

Medication _____

Dosage _____ Route _____

Frequency _____

Date of Order _____ Discontinuation Date _____

Diagnosis _____

Known Drug Allergies _____

Other Medical Conditions _____

Other Pertinent Information: (special considerations, other medications taken by student)

Consent for self administration: Yes _____ No _____

Signature _____

Date _____

Adopted: October 21, 1993
Reviewed by Policy Subcommittee on January 12, 2009

Doctor/Prescriber Must Complete and Sign This Form