

**Granby Public Schools
Medication Order**

(To be completed by a Licensed Prescriber:
Physician, Nurse Practitioner,
or other authorized by Chapter 94C)

Name of Student: _____ Date of Birth: ___/___/___

Address: _____ Grade: _____
(Street) (City/town)

Name of Licensed Pre-scriber: _____ Title: _____

Business Telephone Number: _____

Medication: _____

Dosage: _____ Route of Administration: _____

Frequency: _____ Time of Administration: _____

Specific Directions or information for administration: _____

Date of Order: ___/___/___ Discontinuation Date: ___/___/___

Diagnosis: _____

Any other medical condition(s)**: _____

Optional information:

1. Special side effects, contraindications, or possible adverse reactions to be observed: _____
2. Other medication being taken by the student: _____
_____.
3. The date of the next scheduled visit or when advised to return to pre-scriber: ___/___/___.

Signature of Licensed Pre-scriber

___/___/___
Date

**If not in violation of confidentiality

Revised February 7, 2005

Adopted January 10, 2005

Granby Public Schools – 2004