

Granby Public Schools
Health Clinic
Medication Order

Name of Student _____ Date of Birth _____

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

Name of licensed Prescriber _____ 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, contradiction, 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 prescribe:

Signature of Licensed Prescriber

Date

** If not in violation of confidentiality