

**Encompass Community For Independent Learning
At Friends Academy
PRESCRIPTION MEDICATION ORDER FORM
2018-19**

1088 Tucker Road, North Dartmouth, MA 02747
Phone (508) 999-1356 Fax (508) 997-0117

To be completed by medical provider

STUDENT NAME: _____ DOB: _____

DIAGNOSIS: _____ Allergies _____
(if not in violation of confidentiality or contrary to parent request)

MEDICATION ORDER: Name of Medication _____
Dosage _____
Start Date _____ D/C DATE _____

PLEASE DESCRIBE ANY SPECIAL DIRECTIONS, PRECAUTIONS OR OBSERVATIONS FOR ADMINISTRATION:

Please list other medication this student is taking _____

Signature of Licensed Prescriber _____ Date _____

To be completed by Parent or Guardian

I, _____ give permission for the school nurse or other
(Name of parent or guardian)
designated school personnel to give the following medicine _____
(name of medicine)
to _____ prescribed by _____
(name of student) (name of MD, NP or PA)

I give permission to the school nurse to share with appropriate school personnel any information relative to the prescribed medication's administration. Yes _____ No _____

I give my permission for my child to self administer prescribed inhaler yes _____ no _____

Signature _____ Date _____

