

THE PUBLIC SCHOOLS OF BROOKLINE
SCHOOL HEALTH SERVICES
Physician/PCP Form

LICENSED PRESCRIBER'S ORDERS
CONCERNING THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Child _____ Sex [] Date of Birth _____ School _____ Grade _____

Address _____ Phone _____

Name of Licensed Prescriber _____ Business Phone _____

Address _____ Emergency Phone _____

Medication _____ Dosage _____

Frequency _____ Time(s) of Administration _____

(Note: whenever possible, medication should be scheduled during non-school hours.)

Start Date _____ Discontinuation Date _____

Specific directions or information for administration _____

Side effects, contraindication, adverse reactions _____

YES NO

____ Child requires medication to be given during field trips (to be given by teacher or designated staff).

____ Child requires medication to be given on early release days.

____ Child may self-administer asthma and/or emergency allergic medication if the School Nurse determines it safe and appropriate.

Date of next scheduled visit _____

Diagnosis* _____

Other medical conditions* _____

Currently receiving these additional medication(s)* _____

Signature of Licensed Prescriber _____ Date _____

