*Have your doctor complete this form for prescription and over-the-counter medication.

Prescription/OTC Medication Order Form

Marshfield Public Schools Washington D. C Grade Eight Class Trip

Jane Landry, RN, MEd – 781-319-3814 (office) – 781-319-3969 (FAX)

(form completed by a Licensed Prescriber, Physician, Nurse Practitioner or others authorized by Chapter 94C)

This medical provider order form is to be used for all prescription and over the counter medications **with the exception of** Acetaminophen (**Tylenol**), Ibuprofen (**Advil, Motrin**), Diphenhydramine Hydrochloride (**Benadryl**) and Calcium Carbonate (**Tums**)

Name of Student: ______________________________ DOB: __________

Address: ______________________________ Grade: __________

Name of Licensed Prescriber: ______________________________ Title: __________

Business Telephone: ____________________ Emergency #: ____________________

Medication: ____

Dosage: ____________________ Route of Administration: __________

Frequency: ____________________ Time of Administration: __________

Specific directions / information for administration: ____________________

Side effects, contraindications or possible adverse reactions: ____________________

____

Date of Order: __________ Discontinuation Date: __________ Permission for student to self-administer medication if School Nurse deems it safe and appropriate. Yes____ No____

*DIAGNOSIS: ____

* Other medication taken by student: ______________________________

* provided such information not a violation of confidentiality

Signature of Licensed Prescriber: ______________________________ Date: __________

Signature of Parent: ______________________________ Date: __________