Louisiana School for Math, Science, and the Arts

MEDICATION ORDER

This form must be completed by a licensed physician or dentist.
This form must be filled out for EACH prescription medication taken. Feel free to make additional copies as needed.

Student's Name:		Date:
Diagnosis:		
Medication:	Dosage:	Route:
Time of Administration:	Special Instructions:	
Date of Order:	Date of Discontinuation:	
Other Medical Conditions:		
Allergies:		
Observe for these specific side effects, contraindications, or possible adverse reactions:		

STUDENT SPECIFIC EMERGENCY CARE

If you see this...	***Do this...***

Other medications being taken by the student:		
Date of next visit or when advised to return to physician or dentist:	Consent for self-administration (provided the nurse determines it is safe and appropriate in the school setting)? ❑ Yes ❑ No	
Name of licensed physician or dentist:	Phone Number: ( )	Fax Number: ( )

Street Address:	City	State	Zip:

Signature of Licensed Physician/Dentist

Date

THIS FORM IS REQUIRED <u>IF YOUR CHILD WILL BE TAKING A PRESCRIPTION MEDICATION</u>.
A SEPARATE FORM IS REQUIRED FOR EACH PRESCRIPTION MEDICATION.