Encompass Community For Independent Learning
At Friends Academy
PRESCRIPTION MEDICATION ORDER FORM
2019-20

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_____