

VALLEY WEST SCHOOL
269 Moore St.
Chicopee, MA 01013
Phone 592-6069
Fax 598-8430

Medication Order Form to be completed by a licensed prescriber.

Name of Student: _____ D.O.B. _____

Name of Licensed Prescriber _____ Title: _____

Business Telephone# _____ Emergency Telephone# _____

Medication: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time(s) of Administration: _____
(Please note: Whenever possible, medication should be scheduled at times other than school hrs)

Student may carry inhaler on person. _____

Date of Order _____ Discontinuation Date _____

Diagnosis* _____

Any other medical condition(s)* _____
*if not in violation of confidentiality.

Allergies _____

1. Special side effects, contraindication, or possible adverse reaction to be observed: _____

2. Other medication being taken by the student*: _____

Signature of Licensed Prescriber Date

SIGNATURE PARENT/GUARDIAN DATE TELEPHONE #

SIGNATURE/SCHOOL NURSE DATE