West Cambridge Pediatric & Adolescent Medicine

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AUTHORIZATION TO ADMINISTER MEDICATION

PATIENT_____ DOB _____

MEDICATION _____

DOSAGE_____

ROUTE OF ADMINISTRATION_____

FREQUENCY_____

TIME(S) OF ADMINISTRATION_____

Specific Directions_____

DATE OF ORDER_____ DATE OF DISCONTINUATION_____

DIAGNOSIS (If not a violation of confidentiality) _____
Special side effects, contraindication or possible adverse reactions to be observed:
_____
_____
Consent for self-administration (provided the school nurse determines it is safe and appropriate).
Yes_____ No_____

SIGNATURE OF LICENSED PRESCRIBER_____

DATE_____