West Cambridge
Pediatric and Adolescent Medicine

575 Mount Auburn Street, Suite101
Cambridge, MA 02138

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, contraindications 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_____

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