Arlington School – 115 Mill Street, MS 111, Belmont, MA 02478 – (617) 855-2124

Prescription Medication Order Form for Licensed Prescriber

Student Name _____ DOB _____
Height _____ Weight _____ Gender _____ Grade _____
Primary Address _____
_____ Zip _____

Name of Licensed Prescriber _____
Title _____
Business Name _____
Main No _____ Fax No _____

Please note: ***Use one prescription per order form***
Whenever possible, medication should be scheduled at times other than school hours.

Medication _____ Dosage _____
Route of Administration _____ Frequency _____
Time(s) of Administration _____

Specify directions and/or information for administration _____
_____

Date of Order _____ Date Discontinued _____

Special side effects, contraindications, or possible adverse reactions of which to be observed _____

Date of next scheduled visit to the licensed prescriber _____

If not in violation of confidentiality policy, please supply the following:

Diagnosis: _____

List other medical conditions:
_____

_____ _____
Signature of Licensed Prescriber **Date**

_____
Print Name

FORM M4.01
Last update: Aug-14