Oyster River Cooperative School District
Physician Medication Order

Date:____________________________  School:_____________________________

Student’s Name:______________________________  DOB:____________________

Diagnosis:__________________________________________________________________
(If not a violation of confidentiality)

*Medication:__________________________________________________________________

Directions:______________________________________
_____________________________________________________________________________
_____________________________________________________________________________

*If the above medication is an asthma inhaler, Epi-pen, or insulin, does the student have permission to carry and/or self-administer his/her own medication?_________________________

Duration of time medication is to be administered:_________________________________

Possible side effects:_____________________________________________________________________________
_____________________________________________________________________________

_____________________________________________
Health Provider Signature:

Provider telephone number:____________________________

1) No prescription medication will be given at school without this completed form.
2) The medication must be brought in its original container labeled by the pharmacy or health care provider.
3) All medication brought into school must be kept in the Health Office during school hours.

Please return to the school nurse:

FAX #: ORHS=603-868-1355, ORMS=603-868-3469, MOH=603-742-7569, MW=603-659-8612

Last Modified 2/20/2015