Oyster River Cooperative School District
Physician Medication Order

Date:______________________________ School:_______________________________

Student's Name:____________________________________DOB:_______________________

Diagnosis:____
(If not a violation of confidentiality)

*Medication:____

Directions:____

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*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:____

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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