

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