VALLEY WEST SCHOOL

269 Moore Street, Chicopee, MA 01013
Phone (413) 592-6069 Fax (413) 598-8430
www.valleywestschool.com

Medication Order Form to be completed by a licensed prescriber.
For medications taken during the school day.

Name of Student: ______________________________________D.O.B.________________

Name of Licensed Prescriber: ____________________________Title:_________________

Business Telephone#:__________________Emergency Telephone#_________________

Medication: ____

Route of Administration: ______________________________Dosage:________________

Frequency: ___________________Time(s) of Administration: ______________________
(Please note: Whenever possible, medication should be scheduled at times other than school hrs.)

Student may carry inhaler on person.__________

Date of Order: ________________________________ Discontinuation Date: ___________

Diagnosis*: ____

Any other medical condition(s)*: ____
*if not in violation of confidentiality.

Allergies: ____

1. Special side effects, contraindication, or possible adverse reaction to be observed: ____

____

2. Other medication being taken by the student*: __________________________________

____

__________________________ ____________
Signature of Licensed Prescriber Date

___________________________________ ________________ __________________
SIGNATURE PARENT/GUARDIAN DATE TELEPHONE #

___________________________________ ________________
SIGNATURE/SCHOOL NURSE DATE