Oyster River Cooperative School District Physician Medication Order

Date:	School:	
Student's Name:	DOB:	
Diagnosis:		
(If not a violation of co	onfidentiality)	
*Medication:		
Directions:		
	hma inhaler, Epi-pen, or insulin, does the studer 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