Community Pediatrics
1 Billings Road 1st Floor
Quincy, MA 02171
Tel: 617-773-5400

Medication(s) Order Form

Name of Student: ____ DOB: _______________________

Home Address: ____ Grade: ______________________

Name of Licensed Prescriber: ____

Diagnosis: ____

Medication: ____

Dosage: _________________________________ Route of administration: ________________________________

Frequency: ______________________________ Time of administration: ________________________________

Possible adverse effects: ____

Date of Order: ____________________________ Discontinuation Date: _________________________________

Signature of Licensed Prescriber: ____

Signature of Parent/Guardian: ____

Diagnosis: ____

Medication: ____

Dosage: _________________________________ Route of administration: ________________________________

Frequency: ______________________________ Time of administration: ________________________________

Possible adverse effects: ____

Date of Order: ____________________________ Discontinuation Date: _________________________________

Signature of Licensed Prescriber: ____

Signature of Parent/Guardian: ____