

**Salem Public Schools
Health Services
Licensed Provider Form**

To be completed by a licensed prescriber:
Physician, Dentist, Nurse Practitioner authorized by Ch. 94C

Student Name _____ Date of Birth _____

Address _____ Grade _____

Name of Licensed Prescriber _____

_____ Title _____

Address _____ City / Town _____

Phone _____ Emergency Number _____

Medication _____ Action _____

Route _____ Dosage _____

Frequency _____ Times _____

Specific Instructions

Date of Order _____ Discontinue _____

Date _____

Diagnosis _____

Significant Medical History _____

(if not in violation of confidentiality)

Optional Information

1 Special side effects, contraindications, or possible adverse reactions to be noted

2 Other daily medications _____

3 Date of next scheduled visit to prescriber _____

4 Consent for self administration (provided the school nurse determines it is safe and appropriate) Yes _____ No _____

Signature of Licensed Prescriber _____

Date _____