SCHOOL NAME
ADDRESS
TELEPHONE
FAX

VERBAL MEDICAL ORDER – only for School Nurse/Associate School Nurse use

TO: _____ **Student Name/DOB**

_____ _____

_____ _____

Faxed orders with licensed provider electronic signature and initialed by sending RN is/ is not acceptable (please circle your choice)

New MEDICATION, SERVICE And/or TREATMENT ORDERED
For meds specify details, including end date:

Start Date	End Date	MEDICATION *CHANGES* Medication Name	Strength of med.	Dose	Route	Time

Page ____ of _____

SCHOOL NURSE: _____

SIGNATURE/TITLE OF SCHOOL NURSE ACCEPTING ORDERS:
_____ **DATE:** _____

PRINTED NAME OF Licensed Provider:
_____**DATE:** _____

SIGNATURE OF Licensed Provider:
_____

This order is valid for one dose only until signed and dated by licensed prescribing provider