PEDIATRIC ASSOCIATES OF BROCKTON
(508) 584-1234

Medication Order (Stimulants)

(To be completed by a Licensed Prescriber
Physician, Nurse Practitioner or others authorized by Chapter 94c)

Name of Student_____ Date of Birth_____

Address_____ Grade _____

Name of Licensed Prescriber _____

Medication_____Dose_____

Route of Administration_____Time_____

Special Directions_____

Date of Order_____ Discontinuation Date 1 year

Diagnosis Attention Deficit Hyperactivity Disorder

Other Medical Conditions_____

_____

Optional Information

1. Special side effects, possible adverse reactions; decreased appetite, weight loss, insomnia, irritability, dizziness, headaches, dry mouth, increased blood pressure and heart rate, constipation, drowsiness, abdominal pains, nausea and increased tics.

2. Other medications being taken by student_____

_____

3. The date of the next scheduled visit or when advised to return to MD_____

4. Consent for self-administration (provided that the school nurse determines it is safe and appropriate). YES_____ NO_____

5. Consent to self carry YES_____ NO_____

Signature of Licensed Prescriber_____ Date_____

Signature of Parent/Guardian_____ Date_____