HMS SCHOOL

FOR CHILDREN WITH CEREBRAL PALSY

4400 Baltimore Avenue

Philadelphia, PA 19104

(215) 222-2566 Phone

(215) 662-5159 Nurses' Station Fax

ORDER FOR ADMINISTRATION OF MEDICATIONS/TREATMENTS

Name of Student ____ D.O.B. ___/___/___

Name of Medication With Concentration _______________________________________

Dose and Timing ____

Route of Administration ____

Amount/Volume to be Dispensed ____

Refills __________

Substitution Permissible _____Yes _____No

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" in the space below.

Physician/Nurse Practitioner Name ____

Signature ____ Date ___/___/___

License # _____________________________ Dea # _____________________________

6/13