Bishop Fenwick High School

Licensed Provider Form

Student Name: _____ Date of Birth: _____

Address_____ Grade_____

Name of Licensed Prescriber

_____ Title_____

Address_____ City/Town_____

Phone_____

Medication_____ Action_____

Route of administration_____

Dosage_____

Frequency_____

Times of administration_____

Date of order_____ Discontinue_____

Specific directions for administration: _____

Diagnosis_____

Special side effects, contraindications or possible adverse reactions

_____

_____

Signature of licensed Provider_____

Date_____

Revised BFHS/AEK 09/2012