



Little Keswick School

Incorporated

A Therapeutic, Special Education Boarding School for Boys

MEDICATION INFORMATION FORM (separate form for each medication)

1. Student: _____ Date Ordered: _____ Date Initiated: _____
2. Physician: _____ Address: _____ Telephone Number: _____
3. Medication ordered: (name, form, strength, daily dosage and count)
4. Purpose and desired effect:
5. How much time should it take before desired effects can be expected to occur?
6. Are there any unwanted side effects that we should especially look for?
7. Are there any known interactions with other drugs especially with drugs the client is currently taking?
8. Are there special administration or storage instructions?
9. Is the drug a controlled substance?

I authorize Little Keswick School, Inc. to assign designated employees, Support Counselors, who have successfully completed a medication assistance training program approved by the Board of Nursing, to administer the following medications to the named student. I have informed the clients, families, and/or legally authorized representatives of the potential side effects of prescribed medications.

Date

Physician's signature

_____ If checked, this medication is being restarted from previous order.

Cc: _____ Parent _____ SC's _____ Administrators _____ Headmaster _____ Therapist

_____ Teacher _____ OT _____ Speech _____ Art _____ Shift Supervisors _____ Dorm Counselors

_____ Dorm Log _____ P.E. _____ Office Manager