



Asthma &
Allergy
Physicians

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SCHOOL MEDICATION FORM FOR ANTIHISTAMINES

Patient Name: _____

Date of Birth: _____

Address: _____

Patient's Weight _____

Name of Licensed Provider: _____



35 Pearl St.
Suite 300
Brockton, MA 02301



675 Paramount Dr
Suite 303
Raynham, MA 02767



888 Washington St
Suite 305
Dedham, MA 02026



115 Water St
Suite 203
Milford, MA 01757

Medication: _____

Dosage: _____

Frequency: _____

Route of Administration: _____

Patient's Diagnosis: _____

Date of Order: _____

Discontinuation Date: _____

Possible Side Effects: _____

Consent for self-administration (provided the school nurse determines it is safe and appropriate)

YES _____

NO _____

Signature of Licensed Provider

Date