Phillips Academy
ANDOVER

Phillips Academy
Rebecca M. Sykes Wellness Center
978-749-4455. fax 978-749-4452
E-mail: sykeswellness@andover.edu

Rebecca M. Sykes Wellness Center
MEDICATION ORDER(S)

(To be completed by a Licensed Prescriber or other authorized by Chapter 94C)

Name of Student _____Date of Birth _____

Name of Licensed Practitioner _____ Title _____

Email Address _____ Phone# _____ Fax# _____

All prescriptions must be sent to our preferred pharmacy for blister packaging. Please have your child's prescriber send the prescription to the pharmacy listed below (medications will be delivered to the Wellness Center:
AWP Masspack 6 Executive Park Road, Billerica MA 01821
Phone: 351-207-5132 Fax: 351-207-5136

Please list any other medications being taken:_____
_____

1. Medication/Strength/Form _____ Dosage _____ Route _____ Frequency _____
Specific directions for administration _____
Diagnosis _____
Date of Order _____Discontinuation Date _____ Approved for Self-Admin (if approved by RMSWC Staff): Y☐ N☐
Relevant side effects or adverse reactions: _____

2. Medication/Strength/Form _____ Dosage _____ Route _____ Frequency _____
Specific directions for administration _____
Diagnosis _____
Date of Order _____Discontinuation Date _____ Approved for Self-Admin (if approved by RMSWC Staff): Y☐ N☐
Relevant side effects or adverse reactions: _____

3. Medication/Strength/Form _____ Dosage _____ Route _____ Frequency _____
Specific directions for administration _____
Diagnosis _____
Date of Order _____Discontinuation Date _____ Approved for Self-Admin (if approved by RMSWC Staff): Y☐ N☐
Relevant side effects or adverse reactions: _____

4. Medication/Strength/Form _____ Dosage _____ Route _____ Frequency _____
Specific directions for administration _____
Diagnosis _____
Date of Order _____Discontinuation Date _____ Approved for Self-Admin (if approved by RMSWC Staff): Y☐ N☐
Relevant side effects or adverse reactions: _____

If more space is needed, please use a second form.
Date: _____ Signature of Licensed Provider:_____

Date Modified: _____ Signature of Licensed Provider:_____