Millersville University
HEALTH SERVICES

40 Dilworth Rd
Millersville, PA 17551
hservices@millersville.edu
Phone: 717.871.5250
Fax: 717-871-7926

Medication Administration Order

Please complete and sign this form to provide orders for administering the prescribed medication, per our safety protocol. Any patient receiving medications must have a completed form on file. This form must be updated **annually.**

PLEASE PRINT CLEARLY:

Patient's Name: _____DOB: _____

Physician's Name: _____

Physician's Address: _____

Phone: _____Fax: _____

Medication Oder

Medication Name: _____ Dose: _____ Route: _____

Medication Frequency: _____

Date of last dose: _____ Circle site where last dose was administered: R deltoid L deltoid R thigh L thigh

R ventrogluteal L ventrogluteal R dorsogluteal L dorsogluteal Other site:_____

If patient is late for medication, please provide instructions for administration:

_____

_____

Instructions for withholding medication:

_____

_____

Special Instructions:

_____

_____

Does the patient need to be monitored following medication administration? If yes, how long? _____

_____

Diagnosis: _____

_____ _____

Prescribing Provider Signature Date

****PLEASE FAX COMPLETED FORM TO HEALTH SERVICES AT 717-871-7926**

Millersville University Health Services Office Use Only

Reviewed by _____MD / CRNP Date: _____