Millersville University
HEALTH SERVICES

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MEDICATION ADMINISTRATION ORDER

Prescribing Agent: 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 ORDER

Medication Name_____ Dose _____ Route _____

Medication Frequency_____

Date of Last Dose _____

Please write the site where the last dose was administered:_____

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

_____

_____

Instructions for withholding medication

_____

_____

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

Condition treated with this medication_____

Prescribing Provider Signature _____ Date _____

Millersville University Health Services Use

Reviewed by _____ MD/CRNP Date _____