



Medication Administration Order

Please complete and sign this form to provide orders for administering the prescribed medication to your patient, 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: _____

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: _____