LOYOLA
UNIVERSITY MARYLAND
STUDENT HEALTH SERVICES

4502A North Charles Street
Baltimore, MD 21210
PHONE: 410-617-5055
FAX: 410-617-2173
EMAIL: HealthServices@loyola.edu

Dear Physician,

Thank you for allowing us to participate in your patient's care. For continuity purposes, please complete the attached MEDICATION ADMINISTRATION ORDER FORM at your earliest convenience to avoid interruption in management of our patient's condition.

Please note, this form is intended to help Loyola University Maryland SHS Staff with administering medication. THIS IS NOT A PRESCRIPTION, it is with the expectation that **the student will come to the health center with their medication**.

If there **are any changes in the orders** (*i.e.* medication dose/frequency) please complete a new form. Please call (410) 615-5055 for questions!

Thank you,

Loyola University Maryland SHS Staff

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MEDICATION ADMINISTRATION ORDER

PATIENT NAME:		**DATE OF BIRTH:**
INDICATION FOR THE MEDICATION:		
NAME OF MEDICATION:		
MEDICATION DOSE:	**ROUTE:**	**FREQUENCY:**
OTHER INSTRUCTIONS:		
PRESCRIBING PROVIDER NAME:		**TITLE OF PROVIDER:**
PRESCRIBING PROVIDER SIGNATURE:		
BUSINESS ADDRESS:		
BUSINESS PHONE NO: *PLS INCLUDE BEST TIME TO CALL		**BUSINESS FAX NO.**

Has the prescriber discussed benefits & risks of this medication with the patient? ☐ Yes ☐ No
Has the patient received this mediation before? ☐ Yes ☐ No

*If YES, please document the last (3) **most recent** administration.

DATE / TIME ADMINISTERED	**LOCATION** (*IF PERTINENT)	**COMMENTS** (TOLERATED WELL? NEEDED PREMED? LOCAL RXN?)

NAME & TITLE OF PERSON COMPLETING THIS FORM IF NOT THE PRESCRIBING PROVIDER

Please fax completed form to **(410) 617-2173** and make this in **ATTN TO: MA or RN**