



Student Health Center

Medication, Suture Removal, Wound Care Order Form

Date _____ Student's Cell # _____ BU ID# _____

Please treat _____ DOB _____
(Student's Name)

_____	_____	_____	_____
Medication	Dose	Route	Frequency
Diagnosis _____		Date last given _____	

_____	_____	_____	_____
Suture/Staple	Insertion Date	Location	Removal Date
			# of Sutures/Staples

_____	_____	_____
Wound (Define care below)	Location	Size

Specific Instructions:

Prescribing Medical Provider Signature Date

Print Provider's Name Provider Phone # Provider Fax #

BUSHC Medical Provider's Signature Date

Please note:

- Orders for medications are approved for 1 year.
- The student must hand carry any medication and/or supplies to each Health Center appointment.
- Wounds may need to be re-evaluated by the prescribing Medical Provider at the discretion of the SHC Medical Provider.

Return completed form to:

324 Kehr Union * Bloomsburg University * 400 East Second Street * Bloomsburg, PA 17815-1301
Phone: (570) 389-4451 Fax: (570) 389-3417