

## **HAMPTON CITY SCHOOLS**

## **MEDICATION REQUEST FORM**

Notice to Parents: Medications must be brought to school by the parent or legal guardian in a container that is appropriately labeled by the pharmacy or physician.

Today's Date:		
Name of Student (Last, First, MI):	Student's Date of Birth (M / D/ Y):	
Address:	School:	
Allergies:	Student's Height:	Student's Weight:
Student's Diagnosis:	Duration:  10 days or less	☐ School Year
Medication Name Dosa	age Amount	Route Time
1		
2		
3		
4		
5		
Start Date:	End Date:	
Physician / Nurse Practitioner / Dentist's Name (Please	e Print):	Phone Number:
Physician / Nurse Practitioner / Dentist's Signature:		FAX Number:
Physician / Nurse Practitioner / Dentist's Address:		
I hereby give permission for the school to administer the medication as prescribed above during the school day and on field trips. I also give permission for the school to contact the above health care provider regarding the administration of this/these medication(s).		
Signature - Parent or Legal Guardian:		Date:
Home Phone Number - Parent or Legal Guardian:	Work Phone Number - Parent or Legal Guardian:	
Approved by School Nurse: Signature / Title		Date: