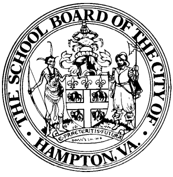

HAMPTON CITY SCHOOLS

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	Dosage	Amount	Route	Time
1.				
2.				
3.				
4.				
5.				

Start Date:	End Date:
Physician / Nurse Practitioner / Dentist's Name (Please 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: