

HILLSBOROUGH HIGH SCHOOL      PHONE # 874-4200      FAX # 874-3762

**\*\*HHS MEDICATION REQUESTS\*\***

**NAME:** \_\_\_\_\_

**GRADE:** \_\_\_\_\_

**PHYSICIAN MEDICATION REQUEST SECTION-To be completed by the DOCTOR ONLY!**

It is necessary for him/her to have the following medication during the overnight trip &/or during the year:

Any medication allergies? \_\_\_\_\_ If yes, please list: \_\_\_\_\_

Medication #1 \_\_\_\_\_ Medication #2 \_\_\_\_\_

Diagnosis \_\_\_\_\_ Diagnosis \_\_\_\_\_

Dosage \_\_\_\_\_ Dosage \_\_\_\_\_

Time to Be Administered \_\_\_\_\_ Time to Be Administered \_\_\_\_\_

*Adverse reactions that may occur for #1* \_\_\_\_\_

*Adverse reactions that may occur for #2* \_\_\_\_\_

Medication #3 \_\_\_\_\_ Medication #4 \_\_\_\_\_

Diagnosis \_\_\_\_\_ Diagnosis \_\_\_\_\_

Dosage \_\_\_\_\_ Dosage \_\_\_\_\_

Time to Be Administered \_\_\_\_\_ Time to Be Administered \_\_\_\_\_

*Adverse reactions that may occur for #3* \_\_\_\_\_

*Adverse reactions that may occur for #4* \_\_\_\_\_

Medication will be administered during the overnight trips & school year.

Starting on: \_\_\_\_\_ and Terminated on: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
PHONE NUMBER      DATE



**\*PARENT/GUARDIAN MEDICATION REQUEST SECTION-To be completed by the Parent/Guardian\***

I hereby give permission for my child to receive medication as prescribed above by my child's physician. I also give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and treatment.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_