Lafayette County Schools

Teacher: _____

School Health Clinic
Medication Administration Permission Form

Student: _____ D.O.B: _____/_____/_____ Grade: _____
First Middle Last Month Day Year

Parent/Guardian:	Work Phone:	Cell Phone:	Home Phone:

PHYSICIAN TO COMPLETE:

Medical Condition/Diagnosis/Prescribed for: _____

***Allergies*: ☐None ☐Yes (foods, medicines, etc.)** _____

Medication Name: _____ Strength/Dose to give (mg, mL): _____

Form (liquid, capsule, tablet): _____ Time(s) to give: _____

Route (oral, inhaled): _____ Potential Side Effects: _____

Start Date: _____/_____/____ End Date (*Last day of school unless otherwise indicated here*): _____/_____/_____

Special Instructions (take with food, on empty stomach, crush, etc.): _____

***Physician Initials*:** _____Student has been *instructed* and is *knowledgeable* on how to self-administer medication (i.e. inhaler, EpiPen, insulin).

***Physician Initials*:** _____This student *may carry* and *self-administer* their medication during school and school activities.

_____ _____ _____ (_____) _____-_____
Physician's Name/Office (*Print/Stamp*) Physician Signature Date Office Phone Number

It is necessary for my student to be given the medication (prescription or over-the-counter) listed above during the school day, including when my student is away from school property at school related activities. I understand a non-medical, trained staff member to be designated by the principal may administer this medication (F.S.1006.062). I give permission for the LCSB staff and DOH clinic staff to contact my child's physician and/or pharmacy in reference to this medication and/or medical condition as needed. I give permission for my student's picture to be taken/used for identification purposes in the clinic.

Date Received (first brought to school): _____/_____/_____ Amount (Pills/Caps/Liquid): _____ _____/_____
Parent Signature/Clinic Staff Initial

Expiration Date (Rx Label): _____/_____/_____ Expiration Date (Mfr): _____/_____/_____

Date *Returned* (end of year/use/need): _____/_____/_____ Amount (Pills/Caps/Liquid): _____ _____/_____
Parent Signature/Clinic Staff Initial

MEDICATIONS NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DESTROYED.
(No medications are kept in clinic over the summer)

Updated: 5/19/2026

Lafayette County Schools

School Year: _____-_____

Medication Inventory Log

*Log and count all medications received and/or removed from the clinic.
**Two staff signatures are needed to count and destroy meds not picked up by parent/guardian.

Date	Medication Name/Dose	Med Count/Type(tab, cap)	Expiration(Label/Mfr)	Parent & Staff Signature
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