Lafayette County Schools Teacher: _____

School Health Clinic
Medication Administration Permission Form

Student: _____ D.O.B: _____/_____/_____ Gender: _____ Grade: _____

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

PHYSICIAN TO COMPLETE:

Medical Condition/Diagnosis student takes medication: _____

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

Medication: _____ Amount/Dosage/Route: _____

Time to be given: _____ Potential Side Effects: _____

Starting Date: _____/_____/_____ Ending Date: _____/_____/_____

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 or 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 during school related activities. I understand a non-medical, trained staff member to be designated by the principal may administer this medication.

By signing below, 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

Date *Returned* (end of year/use/need): _____/_____/_____ Amount (Pills/Caps/Liquid): _____ _____

Parent Signature

MEDICATIONS NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DESTROYED.

(No medications are kept in clinic over the summer)6/2022