



DISPERSION OF MEDICATION FORM

Escambia County Public Schools - Health Services, J. E. Hall Center 30 E. Texar Dr., Pensacola, FL 32503 (850) 469-5456

Please return the completed form to the school health room/office.

I. STUDENT INFORMATION

Student's Name:	Student ID #:	Birthdate:	Grade/ Teacher	Allergies
Parent/Guardian	Address	Work Phone	Home/Cell Phone	

II. ACTION PLAN

THIS REQUEST IS TO BE EFFECTIVE FOR THE **SCHOOL YEAR 20** ____ - **20** ____ Diagnosis: _____ ROUTE: _____

NAME OF MEDICATION & STRENGTH (mg, mcg) _____

LABEL INSTRUCTIONS: _____

DOSAGE TO BE GIVEN AT SCHOOL: _____ TIME TO BE GIVEN AT SCHOOL: _____ POSSIBLE SIDE EFFECTS: _____
(# pills, ml, puffs)

III. PHYSICIAN PERMISSION (To be completed **ONLY** if student is to carry and/or self-administer medication.)

Florida law only allows students with asthma, life-threatening allergic reactions, diabetes, pancreatic insufficiency, or cystic fibrosis, **with parent and physician authorization**, to carry and self-administer the prescribed type of medication as below.

s.1002.20(3)(h), FS Short-Acting Bronchodilator

s.1002.20(3)(k), FS Prescribed Pancreatic Enzyme

s.1002.20(3)(i), FS Epinephrine Device

s.1002.20(3)(j), FS Diabetes Medication and Supplies

This student is both capable and responsible for ☐ carrying and/or ☐ self-administering this medication.

Print Physician's Name: _____ Address: _____ Physician's Signature: _____ Phone: _____ Date: _____

IV. PARENTAL PERMISSION (To Be Completed by Parent/Guardian and witnessed by School District staff or notarized). Form is void if this section is incomplete.

I request the designated school personnel or its agents to assist my child in the administration of the above-prescribed medication. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of the school district, its personnel, or agents, for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up by the last day of the current school year. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of the School District of Escambia County and its agents. I assume all risk and liability with respect to my child's use of epinephrine, including any related injection device, inhalant, insulin, diabetes supplies, or prescribed pancreatic enzyme when authorizing my child to self-administer and/or carry the prescribed medication.

Parent/ Guardian Name: _____ Print _____ Signature _____ Date _____ School Clinic Staff Name: _____ Print _____ Signature _____ Date _____

Notary:

Signed before me in _____, Florida this _____ day of _____ 20 _____. Identification: _____
Known by me Signature of Notary: _____ Notary Stamp: _____

☐ Medication Protocol at School
☐ Parent Responsibilities Given

This Authorization is provided in accordance with Section 1006.062, Florida Statutes.

Revised: 8-27-26

MEDICATION TRACKING LOG

STUDENT NAME _____ STUDENT NUMBER _____ DOB _____ SCHOOL YEAR _____

MEDICATION SIGNED IN

DATE	TIME	MEDICATION & STRENGTH	MED EXPIRATION	LABEL EXPIRATION	AMOUNT SIGNED IN	PARENT/GUARDIAN PRINT NAME	PARENT/GUARDIAN SIGNATURE	CLINIC STAFF INITIALS

MEDICATION SIGNED OUT OR WASTED

DATE	TIME	MEDICATION & STRENGTH	MEDICATION AMOUNT	SIGN OUT=SO WASTED= W	PARENT/GUARDIAN OR CLINIC STAFF PRINT	PARENT/GUARDIAN OR CLINIC SIGNATURE	WITNESS SIGNATURE FOR WASTED MEDS (MAKE COMMENT ON CLINIC NOTE)	CLINIC STAFF INITIALS

****FOR FIELD TRIP USE ONLY**** MEDICATION SIGNED OUT/RETURNED FOR FIELD TRIP ****FOR FIELD TRIP USE ONLY****

DATE	TIME	MEDICATION & STRENGTH	AMOUNT SIGNED OUT	DISTRICT STAFF PRINT & SIGN	AMOUNT SIGNED IN	DISTRICT STAFF PRINT & SIGN	CLINIC STAFF INITIALS

SIGNATURE BANK

INITIALS	PRINT	SIGNATURE /TITLE	INITIALS	PRINT	SIGNATURE/ TITLE