Form: JHCD-F-1

Hamilton Local Schools
PARENT/GUARDIAN MEDICATION CONSENT
(One form required for each medication)

Students needing medication are encouraged to receive the medication at home, if possible.

Only employees of the Board who are licensed health professionals, or who are appointed by the Board and have completed a drug administration-training program conducted by a licensed health professional and considered appropriate by the Board, can administer prescription drugs to students.

The District must receive a written request (Medication Consent Form JHCD-F-1), signed by the parent/guardian having care or charge of the student, before a drug be administered to a student.

To be completed by parent/guardian having care or charge of the student.

Student name: ______________________________ Date of birth: ______________________________
Student address: ____
School building: ____________________ Grade: __________ Class/Homeroom teacher: ____________________

I hereby request and consent to have a Hamilton Local School District employee administer the following medication to my child. I understand and agree that Hamilton Local School District employees who administer a prescribed drug and who has a copy of the most recent statement are not liable in civil damages for administering or failing to administer the drug. I agree to hold the school district and it's employees free from any and all responsibility for the results of such medication or the manner in which it is administered, and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements that may be rendered against them.

I agree to submit a revised Self Medication Consent Form JHCD-F-1 if any of this information should change.

Parent/Guardian printed name: ____
Signature: ____ Date: ____________________

To be completed by prescribing physician or other licensed professional.

Name of the drug to be administered: ____________________ Dosage: ______________ Route: ____________
Times or intervals at which each dosage of the drug is to be administered: ______________________________
Date on which the administration of the drug is to begin: ______________________________
Date on which the administration of the drug is to cease: ______________________________
Any severe adverse reactions that should be reported to the physician: ______________________________
Telephone numbers at which the person who prescribed the medication can be reached in case of an emergency: ______________
Special instructions for administration of the drug, including sterile conditions and storage: ______________________________

As the prescribing physician, I acknowledge that I have prescribed the above named student the stated medication.

Prescribing physician printed name: ____
Signature: ____ Date: ______________

To be completed by the Hamilton Local School District Nurse, or other designee as appointed by the Superintendent.

Only employees of the Board who are licensed health professionals, or who are appointed by the Board and have completed a drug administration training program conducted by a licensed health professional and considered appropriate by the Board, can administer prescription drugs to students. I hereby acknowledge that this written request (Medication Consent Form JHCD-F-1) is complete and has been signed by the parent/guardian and the medication can be administered as indicated.

District employee signature: ____ Date: ______________________

Form JHCD-F-1 approval date: February 13, 2012