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

Form: JHCD-F-2

Hamilton Local Schools
PARENT/GUARDIAN SELF MEDICATION CONSENT
Possession and Use of Asthma Inhalers
(One form required for each medication)

A student may possess and use an Asthma Inhaler during school hours if the District has written approval (Self Medication Consent Form JHCD-F-2) from the student's physician and parent(s)/guardian. The preschool coordinator (preschool), building principal (grades 1- 6), or the district nurse (grades 7-12), must have received and accepted this required written approval (Self Medication Consent Form JHCD-F-2) prior to the student possession and use of an Asthma Inhaler.

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 my child possess and use an Asthma Inhaler during school hours. I understand and agree that in no circumstances will the District, any member of the Board or any Board employee be liable for injury, death or loss of person or property when a District employee prohibits a student from using an Asthma Inhaler because the employee believes, in good faith, that the required written approval (Self Medication Consent Form JHCD-F-2) has not been received by the District. Additionally, liability cannot accrue because the employee permits the use of an Asthma Inhaler when the employee believes, in good faith, that the required written approval (Self Medication Consent Form JHCD-F-2) has been received by the appropriate authority.

I agree to submit a revised Self Medication Consent Form JHCD-F-2 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 medication is to be administered: _____
Date on which the administration of the medication is to begin: _____
Date on which the administration of the medication is to end: _____
Procedures school personnel should follow in the event that the Asthma Inhaler does not produce the expected relief from the student's asthma attack: _____
Any severe adverse reactions that should be reported to the physician: _____
Any severe reactions that may occur to another student for whom the Asthma Inhaler is not prescribed, should he/she receive a dose of the medication: _____
Telephone numbers for the person who prescribed the medication can be reached in case of an emergency: _____
Other special instructions:_____

As the prescribing physician, I acknowledge that the above named student is capable of possessing and using an Asthma Inhaler appropriately and the student has been trained in the proper use of an Asthma Inhaler.

Prescribing physician printed name: _____
Signature: _____ Date: _____

Accepted by the Hamilton Local School District Preschool Coordinator, Building Principal, or District Nurse

I hereby acknowledge that this written approval (Self Medication Consent Form JHCD-F-2) is complete and has been signed by the physician and parent/guardian. The student can possess and use an Asthma Inhaler during school hours as indicated.

District employee signature: _____ Date: _____

Form: JHCD-F-3

Hamilton Local Schools
PARENT/GUARDIAN SELF MEDICATION CONSENT
Possession and Use of Epinephrine Autoinjectors/Epi-pen
(One form required for each medication)

A student may possess and use an Epinephrine Autoinjector/Epi-pen during school hours if the District has written approval (Self Medication Consent Form JHCD-F-3) from the student's physician and parent(s)/guardian. The preschool coordinator (preschool), building principal (grades 1-6), or the district nurse (grades 7-12), must have received and accepted this required written approval (Self Medication Consent Form JHCD-F-3) prior to the student possession and use of an Epinephrine Autoinjector/Epi-pen.

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 my child possess and use an Epinephrine Autoinjector/Epi-pen during school hours. I understand and agree that in no circumstances will the District, any member of the Board or any Board employee be liable for injury, death or loss of person or property when a District employee prohibits a student from using an Epinephrine Autoinjector/Epi-pen because the employee believes, in good faith, that the required written approval (Self Medication Consent Form JHCD-F-3) has not been received by the District. Additionally, liability cannot accrue because the employee permits the use of an Epinephrine Autoinjector/Epi-pen when the employee believes, in good faith, that the required written approval (Self Medication Consent Form JHCD-F-3) has been received by the appropriate authority.

I agree to submit a revised Self Medication Consent Form JHCD-F-3 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 medication is to be administered: _____
Date on which the administration of the medication is to begin: _____
Date on which the administration of the medication is to end: _____
Procedures school personnel should follow in the event that the Epinephrine Autoinjector/Epi-pen does not produce the expected relief from the student's anaphylaxis (allergic response): _____
Any severe adverse reactions that should be reported to the physician: _____
Any severe reactions that may occur to another student for whom the Epinephrine Autoinjector/Epi-pen is not prescribed, should he/she receive a dose of the medication: _____
Telephone numbers for the person who prescribed the medication can be reached in case of an emergency: _____
Other special instructions:_____

As the prescribing physician, I acknowledge that the above named student is capable of possessing and using an Epinephrine Autoinjector/Epi-pen appropriately and the student has been trained in the proper use of an Epinephrine Autoinjector/Epi-pen.

Prescribing physician printed name: _____
Signature: _____ Date: _____

Accepted by the Hamilton Local School District Preschool Coordinator, Building Principal, or District Nurse

I hereby acknowledge that this written approval (Self Medication Consent Form JHCD-F-3) is complete and has been signed by the physician and parent/guardian. The student can possess and use an Epinephrine Autoinjector/Epi-pen during school hours as indicated.

District employee signature: _____ Date: _____