PERMIT FOR DISPENSING PRESCRIPTION MEDICATION

In accordance with Ohio Revised Code 3313.713 Required each school year and at any changes of medication. Hamilton City School District requires that the following information be provided before it will administer medication or treatment to the student.

THIS SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

Student_____**Date of Birth**_____
School_____**Grade**_____ **Home Room**_____

A. I am requesting permission for my child named above to either*: use or receive prescribed medication/receive prescribed treatment/self-administer prescribed medication(s) in my presence or that of an authorized staff member in accordance with the authorized prescription*. **B.** I will assume responsibility for safe delivery of the medication/drug to school. Medication may not be sent to school in the student's lunch box, pocket, back pack, or any other means on or about his/her person. The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist. **C.** I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.) **D.** I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable, unforeseeable for damages or injury resulting directly or indirectly from this authorization.

*If the licensed provider authorizes that the student may possess and use an asthma inhaler and/or an epinephrine autoinjector: . • Parent/Guardian will provide a backup dose of the medication (Epinephrine) to the school principal or nurse as required by law. • It is strongly recommended that Parent/Guardian provide a second inhaler to be stored in the clinic in the event that the student does not have his/her inhaler. • The student should be responsible to report use of inhaler to the nurse and/or principal. • The parent/guardian must sign and date the self-carry authorization at the bottom of this form and the prescriber must check self-carry.

Parent/Guardian Signature:_____**Date:**_____

THIS SECTION TO BE COMPLETED BY LICENSED PRESCRIBER

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student.

Medication Name:_____Diagnosis:_____
Dosage:_____**Route:**_____
Time/Frequency:_____
Start Date:_____**End Date:**_____
Adverse reactions to be reported:_____
Additional Special Instructions or Circumstances:_____

☐ **Check mark box if the student has authorization to *SELF-CARRY* medication for an Asthma Inhaler or an Epinephrine pen**

Prescriber Signature ✖_____**Date:**_____
Prescriber name (print)_____Phone:_____Fax:_____

Parent/Guardian Self-Carry Authorization

o For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered.

o For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian Signature:_____ **Date:**_____

FOR SCHOOL USE ONLY

Nurse's Signature:_____**Date:**_____

Principal's Signature:_____**Date:**_____

School Nurse Contact Information:

Nurse:_____Phone:_____Fax:_____