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: _____