**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:		
understand and agree that Hamilton I most recent statement are not liable i district and it's employees free from	a Hamilton Local School District employee administer the following medication to my child. I Local School District employees who administer a prescribed drug and who has a copy of the n civil damages for administering or failing to administer the drug. I agree to hold the school and any and all responsibility for the results of such medication or the manner in which it is of them against loss by reason of any civil judgment arising out of these arrangements that may		
I agree to submit a revised Self Medic	eation Consent Form JHCD-F-1 if any of this information should change.		
Parent/Guardian printed name:			
Signature:	Date:		
Name of the drug to be administered: Times or intervals at which each dosa Date on which the administration of the	Dosage:Route:		
2 and 311 // mon the definition differ to the	he drug is to begin:		
Date on which the administration of the	he drug is to cease:		
Date on which the administration of the Any severe adverse reactions that should be a severe adverse reaction that should be a severe adverse.	he drug is to cease:ullet be reported to the physician:		
Date on which the administration of the Any severe adverse reactions that show Telephone numbers at which the personal transfer of the personal tr	he drug is to cease:		
Date on which the administration of the Any severe adverse reactions that show Telephone numbers at which the personal special instructions for administration	he drug is to cease:uld be reported to the physician:under the physician can be reached in case of an emergency:		
Date on which the administration of the Any severe adverse reactions that show Telephone numbers at which the person Special instructions for administration As the prescribing physician, I acknow Prescribing physician printed name:	he drug is to cease:		
Date on which the administration of the Any severe adverse reactions that show Telephone numbers at which the person Special instructions for administration As the prescribing physician, I acknow Prescribing physician printed name:	he drug is to cease:uld be reported to the physician:on who prescribed the medication can be reached in case of an emergency: of the drug, including sterile conditions and storage:		

District employee signature:

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.

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 deceive a deceive and the student for whom the Asthma Inhaler is not prescribed, should he/she receive a deceive a deceive and the student for whom the Asthma Inhaler is not prescribed, should he/she receive a deceive and the student for whom the Asthma Inhaler is not prescribed, should he/she receive a deceive and the student for whom the Asthma Inhaler is not prescribed, should he/she receive a deceive and the student for whom the Asthma Inhaler is not prescribed, should he/she receive a deceive and the student for whom the Asthma Inhaler is not prescribed, should he/she receive a deceive and the student for whom the Asthma Inhaler is not prescribed, should he/she receive a deceive and the student for whom the Asthma Inhaler is not prescribed.	To be completed by parent/guardian having care or charge of the student			
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 t no circumstances will the District, any member of the Board or any Board employee be liable for injury, death or loss of pers property when a District employee prohibits a student from using an Asthma Inhaler because the employee believes, in good faith the required written approval (Self Medication Consent Form JHCD-F-2) has not been received by the District. Additionally, lia cannot accrue because the employee permits the use of an Asthma Inhaler when the employee believes, in good faith, that the receivent 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:  Dosage:  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 stu 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 de the medication:  Telephone numbers for the person who prescribed the medication can be reached in case of an emergency:	Student name:	Date of birth: _		
I hereby request and consent to have my child possess and use an Asthma Inhaler during school hours. I understand and agree to no circumstances will the District, any member of the Board or any Board employee be liable for injury, death or loss of pers property when a District employee prohibits a student from using an Asthma Inhaler because the employee believes, in good faith the required written approval (Self Medication Consent Form JHCD-F-2) has not been received by the District. Additionally, lia cannot accrue because the employee permits the use of an Asthma Inhaler when the employee believes, in good faith, that the recurrity 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:  Date:  To be completed by prescribing physician or other licensed professional  Name of the drug to be administered:  Dosage:  Route:  Date on which the administration of the medication is to be administered:  Date on which the administration of the medication is to ond:  Procedures school personnel should follow in the event that the Asthma Inhaler does not produce the expected relief from the stu 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 detent medication:  Telephone numbers for the person who prescribed the medication can be reached in case of an emergency:  Telephone numbers for the person who prescribed the medication can be reached in case of an emergency:  Telephone numbers for the person who prescribed the medication can be reached in case of an emergency:	Student address:			
I hereby request and consent to have my child possess and use an Asthma Inhaler during school hours. I understand and agree to no circumstances will the District, any member of the Board or any Board employee be liable for injury, death or loss of pers property when a District employee prohibits a student from using an Asthma Inhaler because the employee believes, in good faith the required written approval (Self Medication Consent Form JHCD-F-2) has not been received by the District. Additionally, lia cannot accrue because the employee permits the use of an Asthma Inhaler when the employee believes, in good faith, that the recurrity 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:  Date:  To be completed by prescribing physician or other licensed professional  Name of the drug to be administered:  Dosage:  Route:  Date on which the administration of the medication is to be administered:  Date on which the administration of the medication is to ond:  Procedures school personnel should follow in the event that the Asthma Inhaler does not produce the expected relief from the stu 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 detent medication:  Telephone numbers for the person who prescribed the medication can be reached in case of an emergency:  Telephone numbers for the person who prescribed the medication can be reached in case of an emergency:  Telephone numbers for the person who prescribed the medication can be reached in case of an emergency:	School building:	Grade: Class/Homer	oom teacher:	
Parent/Guardian printed name:  Signature:  Date:  To be completed by prescribing physician or other licensed professional  Name of the drug to be administered:  Dosage:  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 begin:  Procedures school personnel should follow in the event that the Asthma Inhaler does not produce the expected relief from the stu 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 dethe medication:  Telephone numbers for the person who prescribed the medication can be reached in case of an emergency:	I hereby request and consent to have me no circumstances will the District, any property when a District employee profester required written approval (Self Medicannot accrue because the employee per profession of the control of the	ny child possess and use an Asthma Inhaler during member of the Board or any Board employee hibits a student from using an Asthma Inhaler be dication Consent Form JHCD-F-2) has not been ermits the use of an Asthma Inhaler when the end	ing school hours. I understand and agree that in e be liable for injury, death or loss of person or ecause the employee believes, in good faith, that a received by the District. Additionally, liability inployee believes, in good faith, that the required	
Signature:	I agree to submit a revised Self Medica	tion Consent Form JHCD-F-2 if any of this info	ormation should change.	
To be completed by prescribing physician or other licensed professional  Name of the drug to be administered:				
Name of the drug to be administered:	Signature:		Date:	
Ouici succiai ilistructions.	Name of the drug to be administered: _ Times or intervals at which each dosage Date on which the administration of the Date on which the administration of the Procedures school personnel should fol asthma attack: _ Any severe adverse reactions that should Any severe reactions that may occur to the medication: _ Telephone numbers for the person who		ot produce the expected relief from the student's s not prescribed, should he/she receive a dose of se of an emergency:	
As the prescribing physician, I acknowledge that the above named student is capable of possessing and using an Asthma In appropriately and the student has been trained in the proper use of an Asthma Inhaler.  Prescribing physician printed name:	As the prescribing physician, I acknow appropriately and the student has been	wledge that the above named student is capal trained in the proper use of an Asthma Inhaler.	ble of possessing and using an Asthma Inhaler	
Signature:	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 the physician and parent/guardian. The student can possess and use an Asthma Inhaler during school hours as indicated.  District employee signature:  Date:	I hereby acknowledge that this writte the physician and parent/guardian. Th	en approval (Self Medication Consent Form JF	HCD-F-2) is complete and has been signed by er during school hours as indicated.	

**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 chand agree that in no circumstances will the of person or property when a District ememployee believes, in good faith, that the reby the District. Additionally, liability can	District, any member of the Board or any Board employee be liangle prohibits a student from using an Epinephrine Autoin equired written approval (Self Medication Consent Form JHCD anot accrue because the employee permits the use of an Epinephrine, that the required written approval (Self Medication Consent Form JHCD).	school hours. I understand able for injury, death or loss njector/Epi-pen because the -F-3) has not been received ohrine Autoinjector/Epi-pen	
I agree to submit a revised Self Medication	Consent Form JHCD-F-3 if any of this information should chan	ge.	
Parent/Guardian printed name:	_		
Signature:	Da	ate:	
Date on which the administration of the mediate of the me	Dosage: the medication is to be administered: dication is to begin: dication is to end: in the event that the Epinephrine Autoinjector/Epi-pen does not ponse): e reported to the physician: nother student for whom the Epinephrine Autoinjector/Epi-pe	produce the expected relief  n is not prescribed, should	
he/she receive a dose of the medication: Telephone numbers for the person who pres	scribed the medication can be reached in case of an emergency:		
Autoinjector/Epi-pen appropriately and the	edge that the above named student is capable of possessing student has been trained in the proper use of an Epinephrine Au		
Signature:	Da	ate:	
I hereby acknowledge that this written approv	trict Preschool Coordinator, Building Principal, or District Nurse val (Self Medication Consent Form JHCD-F-3) is complete and has be and use an Epinephrine Autoinjector/Epi-pen during school hours as inc		
District employee signature:	Date:		