STATE OF HAWAII
DEPARTMENT OF EDUCATION

REQUEST TO STORE AND ADMINISTER EMERGENCY RESCUE MEDICATIONS OR DAILY, ROUTINE, SCHEDULED MEDICATIONS

AT ________________________ SCHOOL FOR ______ - ______ YEAR

Please complete form in ink.

CHILD'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM:	BUS. PHONE: Mother:
ADDRESS:	ZIP CODE:	HOME PHONE:	Father:
Please check ( ) child's health insurance plan: QUEST ☐ MEDICAID ☐ CHAMPUS ☐ HMSA-Private ☐ KAISER-Private ☐ OTHER (specify) ______________ NONE ☐			

I. PARENT'S / LEGAL GUARDIAN'S REQUEST AND AUTHORIZATION

I, the undersigned, request and authorize the personnel of the Department of Education to administer medication as prescribed by my child's physician. I request and authorize the release of health information between the school, the Public Health Nurse, the prescribing physician, and pharmacist pertinent to my child's condition. I understand that a new request is needed should there be any change to the medication order.

☐ I have read the instructions on the back of this request form.

PARENT/LEGAL GUARDIAN NAME: ______________________ (type/print)

PARENT/LEGAL GUARDIAN SIGNATURE: ______________________

DATE: ______________________

II. PHYSICIAN'S REQUEST

DIAGNOSIS: ______________________ WEIGHT: ________

Medication Allergies: ______________________

EMERGENCY RESCUE MEDICATIONS OR DAILY, ROUTINE, SCHEDULED MEDICATIONS:

MEDICATION Name/Dosage/Route	TIME TO BE GIVEN		Reason(s) Medication Need To Be Given During School Day
EMERGENCY RESCUE MEDICATION: ☐ **Epi-Pen Jr, 0.15mg, IM,** outer thigh (33-66lbs) ☐ **Epi-Pen, 0.3mg, IM,** outer thigh (>66lbs)	Upon onset of Life-Threatening Symptoms.	**SYMPTOMS:**	**Rescue Medications** Action for Epi-Pen: Will be administered once and 911 called. Parent will be immediately notified.
EMERGENCY RESCUE MEDICATION: ☐ **Inhaler:**__________ *Dosage/#puffs	Upon onset of Asthma Symptoms.	**SYMPTOMS:**	Action for Inhaler: Will be administered once and parent called for pick-up. 911 will be called as needed.
DAILY, ROUTINE, SCHEDULED MEDICATION: (Med, Dose, Frequency)	Time:		

Physician's Signature: ______________________

DATE: ______________

Physician's Name: ______________________ (type/print)

ADDRESS: ______________________

Telephone: ____________ FAX: ____________

Physician Emergency Contact Number: ______________

Department of Health Public Health Nurse's Recommendation is attached.

Administrator's initial ________ **Date** ________

NOTICE TO PARENTS/LEGAL GUARDIANS AND PHYSICIANS

Please note: School health aides are not licensed health care providers and are not trained or allowed by State law to perform clinical assessments necessary to determine the need for medication.

1. **No medication will be stored in school with the exception of those medications given regularly and Epi-Pen, glucagon and emergency inhalers.**

2. **Medications for daily, routine, and/or life threatening conditions may be administered during the school day. Medications should be given at home as much as possible unless there are reasons, provided by the physician, why it must be given during the school day.**

3. **Antibiotics, analgesics and over-the-counter medications will not be administered at school.**

4. **No "as needed" pro re nata (PRN) medications will be administered during the school day.**

5. **Epi-Pen, Glucagon and inhalers, defined as emergency rescue medication, may be administered on an emergency basis.**
   When Epi-Pen or Glucagon is administered, parent/legal guardian and 911 will be notified. The school will defer to Emergency Medical Service (EMS) personnel with respect as to whether transport to medical facility is needed. If EMS personnel determines that transport to a medical facility is not needed, the parent/legal guardian will be informed to pick up the student.

   When emergency inhalers are administered, parent/legal guardian will be notified to pick up the student.

6. **No medication will be administered by the authorized DOE personnel without the completion of this form, SH36, May 2012, and prior review by an authorized Department of Health Public Health Nurse (PHN).**
   a. Parent/Legal Guardian must complete Section 1, Parent's Request and Authorization.
   b. Physician must complete Section II, Physician's Request.
   c. The completed form should be submitted to the School Health Aide at the school.

7. In order to be administered in school, the medication must:
   a. Be dispensed by a pharmacist in accordance with HAR §328-16 (10).
   b. Be in a container/vial labeled **"FOR SCHOOL USE."**
   c. Include the name of the student, name of the medication, dosage, strength, time of administration, and name of prescribing physician. The instructions on the container must state, **"FOR SCHOOL USE."**

8. Parent/Legal Guardian is responsible for providing an appropriately labeled supply of medication and a recent photo of their child to the Health Room at school. This should be coordinated with the school health aide, child's teacher(s) and school principal.

9. Should there be any change in medication order(s) by the physician, a new "Request for Administration of Medication in School" (SH36 May, 2012) must be submitted and reviewed. The form may be sent to school with the new container/vial of medication to reflect the new order(s).

10. If the School Health Aide is not on duty or if your child is off campus, **NO MEDICATION WILL BE GIVEN FOR THAT DAY unless prior arrangement has been made between parent/legal guardian and school.**

11. This form is good only for the current school year and will need to be renewed yearly. Parents/legal guardians are responsible for submitting requests for the following school year.

SELF-ADMINISTRATION OF MEDICATION FOR SY: ________

A. Parent's Request and Authorization

I, THE UNDERSIGNED, request and authorize my child ____________________ to self-administer his/her medication: **inhaler auto-injectable epinephrine (EpiPen)** while at school.
(Circle one or both as appropriate)

This authorization is given based on the following:

- My child is capable of and has been instructed in the proper method of self-administration of this medication.
- I understand that my child shall be permitted to carry at all times his/her medication as long as he/she does not endanger him/herself, or endanger other persons, and will not misuse the medication.
- I understand that if my child misuses or exceeds the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication.

Parent/Guardian Signature: ____________________ **Date:** ________

I, THE UNDERSIGNED,

- understand that the Department of Education, its employees or agents shall not incur any liability as a result of any injury arising from the self-administration of the medication by my child;
- shall exempt from liability and hold harmless school employees or agents against any claims arising out of the self-administration of medication by my child;
- understand that this authorization shall be effective for this current school year and must be renewed annually.

Parent/Guardian Signature: ____________________ **Date:** ________

B. Physician's Certification

I, THE UNDERSIGNED, certify that ____________________ has asthma,
(student's name)

anaphylaxis or another related potentially life-threatening illness ______________, and
(specify)

he/she is capable of and has been instructed in the proper method of self-administration of

his/her own inhaler and/or auto-injectable epinephrine (EpiPen) medication.
(circle appropriate medication)

Physician's Name: ____________________ **Physician's Signature:** ____________________
(type/print)

Address: ____________________ Telephone: __________ Date __________

Reviewed/Accepted by: ____________________ Date: __________
Principal or DOE Designee

Received by PHN/SHA: ____________________ Date __________