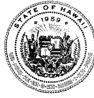

STATE OF HAWAII
DEPARTMENT OF EDUCATION

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**