

REQUEST FOR ADMINISTRATION / STORAGE OF MEDICATION

AT _____ SCHOOL FOR _____ - _____ YEAR

Please complete form in ink.

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

I. PARENT'S REQUEST AND AUTHORIZATION

I, the undersigned, request and authorize the Public Health Nursing Branch (PHNB) personnel to administer/store medication as prescribed by my child's physician. I request and authorize 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 to be processed should there be any change in medication.

PARENT'S/ LEGAL GUARDIAN NAME: _____ (type/print) PARENT'S/ LEGAL GUARDIAN SIGNATURE: _____
DATE: _____

II. PHYSICIAN'S REQUEST

DIAGNOSIS: _____ WEIGHT: _____

Medication Allergies: _____

POLICY: Medications for chronic illnesses and/or life threatening conditions shall be administered during the school day. An order for other medications requires reason(s) for its administration during the school day.

SCHEDULED MEDICATIONS FOR CHRONIC ILLNESS AND/OR LIFE THREATENING CONDITION:

| MEDICATION Name/Dosage | EXACT TIME OR RANGE OF TIME TO BE GIVEN | SPECIAL INSTRUCTIONS | Reason(s) Medication Need To Be Given During School Day |
|------------------------|---|----------------------|---|
| | | | |
| | | | |

PRN MEDICATION:

| MEDICATION Name/Dosage/Frequency | SPECIFIC INDICATIONS FOR USE | REASON(S) WHY PRN MEDICATION IS NEEDED IN SCHOOL (REQUIRED RESPONSE) |
|----------------------------------|------------------------------|--|
| | | |
| | | |

Physician's Signature: _____

DATE: _____

Physician's Name: _____
(type/print)

ADDRESS: _____

Telephone: _____ FAX: _____

Physician Emergency Contact Number: _____

| | |
|---|--|
| DEPARTMENT OF HEALTH AUTHORIZATION | |
| Authorization to SHA/LPN by: | |
| _____ PHN | |
| DATE _____ | |

INSTRUCTIONS FOR REQUEST FOR ADMINISTRATION/STORAGE OF MEDICATION IN SCHOOL

GENERAL INSTRUCTIONS:

1. Medications for chronic illnesses and/or life threatening conditions shall be administered during the school day. Medications should be given at home as much as possible.
2. Antibiotics will not be administered unless there are no other alternatives and physician provides reasons why it must be administered during the school day.
3. Over the counter medications (OTC) will not be administered unless the physician provides reasons why it must be administered during the school day.
4. **No medication will be stored in the Health Room or administered by the authorized Public Health Nursing Branch and/or DOE personnel without the completion of this form, PHN/SH 36, Rev. 6/05, and prior approval by PHNB personnel. This applies to OTC medications.**
 - a. Parent/Legal Guardian must complete Section I, Parent's Request and Authorization.
 - b. Physician must complete Section II, Physician's Request.
 - c. Parent/Legal Guardian is to return this completed form to the Health Room at the school or to the Public Health Nurse
5. Medication must be in a container/vial dispensed by the Pharmacist with instructions **"FOR SCHOOL USE"** with the name of the student, name of the medication, dosage, strength, time of administration, and name of prescribing physician. **This applies to OTC medications, if prescribed.**
6. Parent/Legal Guardian is responsible to send medications to Health Room at school. If there are concerns in getting the medication to the health room safely, parents should call the PHN. Parent/legal guardian is to:
 - a. Send the container/vial of medication labeled **"FOR SCHOOL USE."** Medication(s) will only be accepted if medication is in the container/vial labeled by the Pharmacist, which is the same as the written request (PHN/SH 36) by your child's physician.
 - b. Send in refills in a timely manner in properly labeled container/vial before medication runs out.
 - c. Provide a picture of your child to the School Health Aide/Special Needs Nurse.
 - d. Remind child to report to the Health Room at the designated time.
7. Should there be any change in medication order(s) by the physician, a new "Request for Administration/Storage of Medication in School" (PHN/SH 36 Rev. 6/05) must be processed. The form should be sent to school with a new container/vial of medication to reflect the new order(s).
8. If the Public Health Nursing personnel/ School Health Aide are 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.**
9. This form is good for the current school year and needs to be renewed yearly. Parent/legal guardian is responsible to obtain the form for the following school year.
10. Policies and Guidelines for Administration/Storage of Medications developed by the Hawaii Chapter of Academy of Pediatrics-PHNB-DOE (H-AAP-PHNB-DOE), the PHN/SH 36 form, and General instructions are available at the website address: <http://www.hawaii.gov/health/family-child-health/publichealthnursing/index.html>. Or contact your Public Health Nurse.