KAMEHAMEHA SCHOOLS
Health Services

INSTRUCTIONS FOR REQUEST FOR ADMINISTRATION OF MEDICATION

1. The *Request for Administration of Medication* form is required and initiated when any medication (prescription and/or prescribed over-the-counter) must be administered in school and it is not possible to schedule all dosages at home. ***A separate Request for Administration of Medication form must be completed for each individual medication.*** Medication shall be stored in the Medical/Health Services Department and administered by KS Medical/Health staff with the exception of the following:

   A Middle or High School student may be permitted to carry and self-administer a medication **only if**:

   a) Parent and prescribing health care provider (MD, DO, PA or NP) deem the student responsible to remember to take prescribed doses as directed.
   b) Prescribing health care provider certifies (by completing and signing Section II of this form), the student knows what the medication is for, when to take a dose & is able to safely self-administer the medication.
   c) The medication does **not** require refrigeration.
   d) Controlled substances or mood disorder medications will not be allowed to be self-administered. These medications must be dispensed through Hale Ola or other dispensary for day and boarding students.
   e) The medication is **appropriately labeled by a pharmacist or health care provider** to include:

      - ✓ student's name
      - ✓ medication name
      - ✓ quantity, dosage and time to be taken
      - ✓ date of prescription and name of prescribing health care provider

2. An Elementary school student may have the option of carrying and self-administering medications **only** for asthma, anaphylaxis, or another potential life-threatening illness. The above requirements "1 a through e" must be met. The other option is for the medications may be stored in the health room for administration by the nurse during school.

3. Parents/Legal Guardians must complete Section I.

4. The prescribing health care provider must sign & complete Section II.

5. When Sections I & II are completed, return this form to the appropriate Medical/Health Services Department for approval / acknowledgement by the Medical Director.

6. No medication will be stored or administered by the Medical/Health Services Department without prior approval and completion of this form.

7. Upon approval of this request parents are to:

   a) Be sure the medication is in a container **labeled by the pharmacist / health care provider as required in 1e.**
   b) Remind child to report to the dispensary at the prescribed time. Kamehameha Schools cannot not assume the responsibility for reminding your child to report for his/her medication.

8. This form will be effective for the current school year and **must be renewed annually**.

Dr. Kenneth Fink
Medical Director

Rev 02/2016

Campus – Maui (Circle One): Elementary – Middle – High **School Year _____ / _____**

REQUEST FOR ADMINISTRATION OF MEDICATION

(***One medication or condition per form)***

Section I. Parent/Legal Guardian Request and Authorization

I/We, the undersigned, request and authorize Kamehameha Schools Medical/Health Services staff to administer medication to _____, as prescribed by his/her physician / health care provider.

(Student's Name) (Grade) (Rm)

I/We understand that this request pertains to prescription medications as well as regularly used prescribed over-the-counter medications which are either:

a) Administered by the Medical/Health Services Department OR

b) Self-administered for middle/high school students/(elementary school-emergency medication only) if requested by parents and prescribing health care provider and meet requirements outlined in points 1a through 1d of "Instructions for Administration of Medication" on reverse side of this page. I/We also understand that any changes in medication or dosages must be in writing from the prescribing health care provider.

I/We hereby release and agree to indemnify, defend and hold forever harmless the Kamehameha Schools, its trustees, representatives, agents and employees from and against any and all claims arising from personal injury and/or property damage resulting from the administration of medication consistent with this request.

If my child is self-administering medications, I also understand that Kamehameha Schools is not responsible for ensuring the medication is taken. Kamehameha Schools staff **will immediately confiscate medication shared with classmates and remove student's privilege of self-administration**.

_____ _____ _____

(Signature of Father/Legal Guardian) (Printed Name of Father/Legal Guardian) (Date)

_____ _____ _____

(Signature of Mother/Legal Guardian) (Printed Name of Mother/Legal Guardian) (Date)

Section II. Request of Physician / Prescribing Health Care Provider

Specific diagnosis for which medication is prescribed: _____

Medication name: _____ Dosage:_____

Route: ❒ PO ❒ Nebulized ❒ eye gtts ❒ ear gtts ❒ SC ❒ Other:_____

Time to be administered (during school hours): _____ ❒ prn _____

❒ Medication to be administered until: ____/____/____ **OR** ❒ End of Current School Year

Possible reaction(s) that should be reported to prescriber _____

Please list restriction of activities (if any): _____

❒ Medical/Health Services Administered

OR

❒ Self-administered - I certify that the above named student may safely self-administer the medication(s) specified above. *(Student understands what the medication is for, when to take a dose & can safely self-administer the medication.)*

_____ ____/____/____ _____ _____

(Physician/Health Care Provider's Signature) (Date) (Phone) (Fax)

_____ _____

(Print Physician / Health Care Provider's Name) (Address)

Section III. Medical Director's Acknowledgement/Approval

The above request has been reviewed and the medication will be administered at school as requested.

_____ ____/____/____

(Medical Director) (Date)