KAMEHAMEHA SCHOOLS®

MEDICAL FORMS: Kamehameha Schools Summer Programs
Hoʻomākaʻikaʻi 2026

The program that your child is applying to is a rigorous and active summer learning program. Participation in the program is entirely voluntary. If medical conditions change at any time, please contact your Health Room to update your child's medical record.

REQUIREMENTS

To ensure all haumāna are healthy and ready to participate, families of invited students must complete the following:

1. Health Summary
2. TB Risk Assessment
3. KS Physical Evaluation Form – dated on or after **January 1, 2025**
4. Current immunization record with up-to-date immunizations per the Hawaiʻi Department of Health (HDOH)
    a. Please note that the HDOH requires proof of Hepatitis A vaccination for school entry.

INSTRUCTIONS

1. Please complete all medical clearance requirements in the Moʻomōʻali Olakino (EHR) Parent Portal. Details on how to complete requirements and submit forms will be provided upon acceptance into the program. Submission of medical forms alone does NOT confirm enrollment to the program.
2. Health Summary and TB Risk Assessment:
    a. Log into the Moʻomōʻali Olakino (EHR) Parent Portal to complete these requirements.
3. Physical Evaluation Form:
    a. Complete the Health History form (page 3 of this packet) and give it to your child's healthcare provider with the KS Physical Evaluation Form (page 4 of this packet).
    b. The date of the physical examination must be **on or after January 1, 2025**. If your child already had a physical examination after this date, your child's doctor can complete the KS Physical Evaluation Form based on that physical examination.
    c. The KS Physical Evaluation Form must be signed by a physician, nurse practitioner, or physician assistant.
    d. Upload the KS Physical Evaluation Form to the Moʻomōʻali Olakino (EHR) Parent Portal. Do NOT upload the Health History.
4. Immunization Record:
    a. Ask your child's healthcare provider for a printout of your child's current immunization record with documentation of having been fully immunized based on age with the vaccinations required for each grade outlined below.

Required Vaccination	K-6	7-10	11-12
Diphtheria-Tetanus-Pertussis (DTP or DTaP)	✓	✓	✓
Hepatitis A	✓	✓	✓
Hepatitis B	✓	✓	✓
Measles-Mumps-Rubella (MMR)	✓	✓	✓
Polio (IPV or OPV)	✓	✓	✓
Varicella (chickenpox)	✓	✓	✓
Tetanus, diphtheria, acellular pertussis (Tdap)		✓	✓
Human papilloma virus (HPV)*		✓	✓
Meningococcal conjugate vaccine (MCV)		✓	✓
Meningococcal conjugate vaccine (MCV)**			✓

*Two does are required if <age 15 years at initial vaccination; three does if age 15 years or older.

**One dose of MCV administered after age 16 years is required.

5. Students with Medical Conditions: If your child has a medical condition such as diabetes, seizures, or severe allergy requiring EpiPen, additional health forms must be completed to ensure their safety and full participation in program activities.

a. Seizure diagnosis:
    i. If your child has a seizure diagnosis, the **Medical Clearance for Students with Seizures Participation in Aquatics Activities** form must be completed by both the parent/guardian and your child's healthcare provider. This form can be downloaded from www.ksbe.edu/malama-ola/forms.
    ii. A **Request for Administration of Medication (RAM)** form must also be completed for any prescribed rescue medications.
    iii. Please note that families must identify an adult chaperone for students with seizures participating in water activities. Volunteers serving in this role will need to complete the KS volunteer process.
b. Diabetes:
    i. If your child has diabetes, the **Diabetes Management Plan** must be completed by both the parent/guardian and your child's healthcare provider. This form provides critical information for monitoring your child's health and ensuring that supplies and support are available during program activities. This form can be downloaded from www.ksbe.edu/malama-ola/forms.
    ii. A **Request for Administration of Medication (RAM)** form should be completed for any required prescription medication.
c. Severe allergy requiring EpiPen:
    i. If your child has a severe allergy requiring EpiPen, the medication should be brought to campus with your child each day and a **Request for Administration of Medication (RAM)** form should be completed.

6. Prescription Medications:
    a. If your child requires necessary, prescription medications to be administered while attending the program, please complete the **Request for Administration of Medication (RAM)** form (page 6 of this packet). Instructions for completing the RAM form can be found on page 5 of this packet.
    b. *Please note: Our Health Rooms have acetaminophen, ibuprofen (liquid, chewable, and tablet), loratadine, and chewable TUMS in stock. These medications can be given to your child during the program if needed, with your permission.*

QUESTIONS?

1. Email **hmkkmalamaola@ksbe.edu** with any questions related to medical requirements.
2. Please include your child's full legal name, island of residence, your name, and contact information in your correspondence.

Health History

Instructions: Complete this page and give it to your healthcare provider to review. Do NOT upload this page to the Mo'omõ'ali Olakino (EHR) Parent Portal.

Student Name: _____ **Date of Birth**: _____

General Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
Heart Health Questions About You	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High Blood Pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
Heart Health Questions About Your Family	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
Bone and Joint Questions	**Yes**	**No**
17. Have you ever had any stress fracture, broken or fractured bones, or dislocated joints?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
19. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)?		
20. Do you regularly use a brace, orthotics, or other assistive device?		
21. Have you ever had or do you currently have a bone, muscle, or joint injury that bothers you?		
22. Do any of your joints become painful, swollen, feel warm, or look red?		
23. Do you have any history of juvenile arthritis or connective tissue disease?		

Medical Questions	Yes	No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. In the past year, have you used an inhaler or taken asthma medicine?		
26. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
27. Do you have groin pain or a painful bulge or hernia in the groin area?		
28. Have you had infectious mononucleosis (mono) within the last month?		
29. Have you had a herpes or MRSA skin infection?		
30. Have you ever had a head injury or concussion? If so, date of last occurrence:		
31. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
32. Do you have a history of seizure disorder?		
33. Do you have headaches with exercise?		
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
35. Have you ever been unable to move your arms or legs after being hit or falling?		
36. Have you ever become ill while exercising in the heat?		
37. Do you get frequent muscle cramps when exercising?		
38. Do you or someone in your family have sickle cell trait or disease?		
39. Have you had any problems with your eyes or vision?		
40. Have you had any eye injuries?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42. Do you worry about your weight?		
43. Are you trying to or has anyone recommended that you gain or lose weight?		
44. Are you on a special diet or do you avoid certain types of foods?		
45. Have you ever had an eating disorder?		
46. Do you have any concerns that you would like to discuss with a doctor?		
47. Do you take any nutritional or dietary supplements?		
48. Have you ever tested positive for COVID-19?		
Females Only	**Yes**	**No**
49. Have you ever had a menstrual period?		
50. How many periods have you had in the last 12 months?		

For "Yes" responses, provide details below (use additional sheets if needed):

_____

Signature of Parent/Guardian Date

KAMEHAMEHA SCHOOLS PHYSICAL EVALUATION FORM (K-12)

Instructions: Complete the top line and have your healthcare provider complete the rest. **Ensure all fields are completed before uploading this form to the Moʻomōʻali Olakino (EHR) Parent Portal**. Do NOT upload the Health History.

Student Name: _____ **Date of Birth**: _____ **Grade Entering**: ___ **ID #**: _____

PROVIDER TO COMPLETE Blank fields will be considered as None or Normal		
Medical and Mental Health Conditions:	h/o COVID-19: ☐Yes ☐ No If yes, date of last test: _____ Severity of illness:	**Allergies/Reactions**:
Current Medications & Dosage:	Epi-Pen: ☐Yes ☐No Albuterol Inhaler: ☐Yes ☐No	**Additional Comments:**

Exam Date:	**Height:**	**Weight:**	**BMI:**
BP:	**Pulse:**	**Vision:** R 20 / L 20 /	**Corrected** ☐Yes ☐No

Assessment	Normal	Abnormal Finding
Appearance • Marfan stigmata		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
Musculoskeletal • Neck/back • UE/shoulder/elbow/wrist/hand • LE/hip/knee/ankle/foot • Functional/duck walk/single leg hop		
Mental Health • Depression • Tobacco/Vaping Use		

MEDICAL CLEARANCE

Indicate 'Yes' or 'No' to show whether the student is medically cleared for the following activities.

Please complete all sections. Any section left blank will be considered "not cleared" and the student will not be able to participate in the activity.

	Yes	No	Restrictions or other Comments
School			
Physical Education			
Sports			

I have reviewed the Health History and completed the physical examination documented on this form for the above-named student. Based on my clinical assessment, the student is cleared to attend school and participate in physical education and sports as indicated above. I attest that I am a licensed physician (MD, DO), Nurse Practitioner (NP or APRN), or Physician Assistant (PA).

Name of Provider _____ Signature _____

Address _____ Phone _____ Date _____

KAMEHAMEHA SCHOOLS

MĀLAMA OLA ● Health Services Department

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 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. If the student will be self-administering an over-the-counter medication, Section II must be completed by the parent but a prescriber's signature is not required.

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

6. No medication will be stored or administered by the 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.

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

9. **This form does not create any kind of contract with Kamehameha Schools, nor does it create or confer any legal rights.**

Rev 12/2025

KAMEHAMEHA SCHOOLS
MĀLAMA OLA HEALTH SERVICES DEPARTMENT

REQUEST FOR ADMINISTRATION OF MEDICATION (RAM)

(One medication per form)

Student's Name: _____ _____
Last First

Date of Birth:____/____/____ Grade Entering:_____ Student ID: _____ School Year: _____

Section I. Agreement and Release by Parent/Legal Guardian(s)

1. I/We, the undersigned, request and authorize Kamehameha Schools Health Services staff or their designee to administer medication, as prescribed by his/her health care provider, to my/our child named above and understand that Kamehameha Schools cannot assume the responsibility for reminding my/our child to report for his/her medication. **OR**

   ❒ **I/We deem my/our child is responsible to remember to take prescribed doses as directed, that my/our child knows what the medication is for, when to take a dose & is able to safely self-administer the medication.**

2. I/We understand that this request pertains to prescription medications as well as regularly used over-the-counter medications.
3. I/We understand that any changes in medication or dosage must be in writing and signed by the prescribing health care provider.
4. I/We also understand that this is not a contract.

_____ _____
Signature of Parent/Legal Guardian Printed Name of Parent/Legal Guardian

Date_____

Section II. Medication Information from Prescribing Healthcare Provider

****If your child will be self-administering an over-the-counter medication, this section must be completed, but a prescriber's signature is not required.*

Diagnosis:_____Medication name/dose: _____

Directions for use: _____

❒ Medication to be administered by KS Health Services staff OR ☐ Allow student to self-administer

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

Name of Prescriber_____ Phone_____

Address_____

Signature of Prescriber_____ Date_____

Office Use Only

The above request has been reviewed and request approved.

_____ _____
HSM/SHD or Designee Date