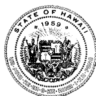

STATE OF HAWAII

DEPARTMENT OF EDUCATION

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

AT ________________________________ SCHOOL FOR ______ - ______ SCHOOL YEAR

Please complete this form in ink.

STUDENT'S NAME (Last, First):		BIRTHDATE:	GRADE/HOMEROOM #
HOME ADDRESS:		HOME PHONE:	
Parent 1/Legal Guardian's Name:	Home Ph #:	Cell #:	Work #:
Parent 2/Legal Guardian's Name:	Home Ph #:	Cell #:	Work #:
Legal Guardian's Name	Home Ph #:	Cell #:	Work #:
Please check student's health insurance plan: QUEST ☐ MEDICAID ☐ TRICARE ☐ HMSA-Private ☐ KAISER-Private ☐			
OTHER (specify): NONE ☐			

I. PARENT'S / LEGAL GUARDIAN'S REQUEST, AUTHORIZATION, and WAIVER OF LIABILITY

<u>Request and Authorization:</u>

I, the undersigned, request and authorize the following individuals to administer medication to my child as prescribed by my child's physician or other practitioner with prescribing authority in a medication order: personnel of the Department of Education (DOE), personnel of the Department of Health (DOH), and nurses assigned by the DOE pursuant to a written agreement.

I request and authorize the release of health information among the DOE, the DOH Public Health Nurse (PHN), the prescribing physician or other practitioner with prescribing authority, and the dispensing pharmacist pertinent to my child's condition. I understand that I will be informed by the PHN, the prescribing physician or other practitioner with prescribing authority if there are any changes to my child's medication order.

- ☐ **I have read the instructions on page 3 of this request form, "Notice to Parents/Legal Guardians and Physicians."**
- ☐ **I will provide a recent photograph of my child.**
- ☐ **I agree I am responsible to provide appropriately labeled medications in accordance with the instructions on page 3 of this request form.**

PARENT'S/LEGAL GUARDIAN'S SIGNATURE: ________________________________

PARENT'S/LEGAL GUARDIAN'S (Type/Print): ________________________________

DATE: __________________

<u>Waiver of Liability:</u>

NOTICE: The DOE, the DOH, and their employees and/or agents shall not incur any liability as a result of any injury arising from the administration of the emergency rescue medications or daily, routine, scheduled medications specified on this form.

My signature below indicates that:

- I understand and I agree that the medication may be administered by a specifically trained non-health care professional; and
- I agree that the DOE and the DOH and their employees or agents, including nurses assigned by the DOE pursuant to a written agreement, shall not incur any liability as a result of any injury arising from the administration of the emergency rescue medications or daily, routine, scheduled medications specified on this form.

PARENT'S/LEGAL GUARDIAN'S SIGNATURE: ________________________________

PARENT'S/LEGAL GUARDIAN'S (Type/Print)**:**________________________________

DATE: __________________

Student's Name: ____**Birthdate:**______________________

II. PHYSICIAN'S or OTHER HEALTH PROFESSIONAL'S REQUEST

DIAGNOSIS: ____

WEIGHT: __________ ALLERGIES: ____

EMERGENCY RESCUE MEDICATIONS AND DAILY, ROUTINE, SCHEDULED MEDICATIONS:

EMERGENCY RESCUE MEDICATION (Name/Dosage/Route)	TIME TO BE GIVEN	DESCRIPTION OF	OTHER ADMNISTRATION INFORMATION Rescue Medications
EMERGENCY RESCUE MEDICATION -- Epinephrine: □ **Epinephrine auto-injector,** Premeasured dose of **0.15 mg**, IM (33-66 lbs) □ **Epinephrine auto injector,** Premeasured dose of **0.3 mg**, IM (>66 lbs)	**First administration**: immediately **upon onset** of life-threatening symptoms. **Second administration:** Repeat dose in ___ minutes of first administration.	**Life threatening SYMPTOMS:** (any one or more) Hives, itching, and flushed or pale skin Swelling of the face, eyes, lips, or throat Wheezing and trouble breathing Weak and rapid pulse Nausea, vomiting, or diarrhea Dizziness, fainting, or unconsciousness Other (fill in):	**Actions for Epinephrine:** The school shall call 911 immediately after first administration. The school shall notify the parent/legal guardian after calling 911.
EMERGENCY RESCUE MEDICATION -- Inhaler: □ **Inhaler (Name):** Albuterol (90 mcg/puff) Levalbuterol (45 mcg/puff) **Dosage**____________**/#puffs:**__________ (6 puffs can be used for >/=5 year olds. Do NOT prescribe a range of puffs such as 4 to 6) Use with valved-holding chamber (will need to be prescribed one for school, make sure prescribe with or without facemask as appropriate)	**Upon onset of Asthma Symptoms.** Repeat dose in 15 minutes of first administration if continues to have asthma symptoms as described in next column	**Asthma SYMPTOMS:** (any one or more) Shortness of breath Chest tightness Wheezing Frequent coughing Other: (fill in)	**Action for Inhaler:** If assigned nurse is available, nurse can assist, assess student for decision on disposition. If no nurse is available, call parent to pick up student after administration of medication per SHA Manual procedure. Call 911 if indicated in student's Emergency Action Plan.

DAILY, ROUTINE, SCHEDULED MEDICATION (Medication/Dose/Frequency/Route)	TIME(S) TO BE GIVEN:	Reason(s) medication(s) need(s) to be given during the school day:

The above indicated medication(s) is/are necessary for the health of the student and for the student's attendance at school and school related functions: □ **Yes** □ **No**

Physician's (or other practitioner with prescriptive authority) Signature*:* ______________________________ DATE: ____________

Physician's (or other practitioner with prescriptive authority) Name (type/print): ____

Telephone: ____________________ FAX: ____________________

Address: ____ City: _______________ Zip: _______________

Note: SH36 review and consultation has been completed by an agent of the DOH. Administration of medication to the above named student as requested by the parent/legal guardian and prescribed by the physician

☐ **is approved by the DOH for administration in the school setting.**

☐ **is not approved by the DOH for administration in the school setting.**

DOH PHN's initial: ______ **Date:** ______________________

NOTICE TO PARENTS/LEGAL GUARDIANS AND PHYSICIANS
(Please keep this page for your future reference.)

Please note: School health assistants are unlicensed non-health professionals who are specifically trained in medication administration. They are not able to perform clinical assessments necessary to determine the need for medication or response to medication, but they are provided with protocols to follow in situations where medication is needed.

1. Medications that are provided by the parent/legal guardians pursuant to this form, shall be stored in the school health room. No other medications will be stored in school.
2. Medications should be given at home as much as possible unless the physician or other practitioner with prescriptive authority provides reasons on this form why medications must be given during the school day or at a beyond-the-school day event/program. In that event, emergency rescue medications and daily, routine, scheduled medications shall be administered as prescribed and requested by this form.
3. Antibiotics, analgesics, and over-the-counter medications will not be stored or administered at school.
4. No “as needed” pro re nata (PRN) medications will be stored or administered during the school day because school health aides administering medication are not able to perform clinical assessments necessary to determine the need for medication.
5. Epi-Pen, Glucagon and inhalers, defined as emergency rescue medications, may be administered on an emergency basis if they have been prescribed by a physician or other practitioner with prescriptive authority, and the parent/legal guardian has requested their administration in accordance with this form, or with Hawaii Revised Statutes (HRS) §302A-853.
   Epi-Pen or Glucagon: When administered, the school will call 911 and notify the parent/legal guardian. The school will defer to Emergency Medical Service (EMS) personnel with respect to whether transport to a medical facility is needed. If EMS personnel determine that transport to a medical facility is not needed, the parent/legal guardian will be informed to pick up the student.
   Emergency inhalers: When administered by an unlicensed non-health professional, the school will notify the parent/legal guardian to pick up the student. When administered by the assigned nurse, the nurse may assess the student and determine whether to allow the student to remain in school or be sent home.
6. No medications will be administered by the authorized DOE or DOH personnel without the completion of this SH36, Revised 2021, which includes the following requirements:
   a. Parent/legal guardian must complete Section I, PARENT’S/LEGAL GUARDIAN'S REQUEST, AUTHORIZATION, and WAIVER of LIABILITY;
   b. Physician or other practitioner with prescriptive authority must complete Section II, Physician’s or Other Health Professional's Request;
   c. DOH must approve the form; and
   d. The completed form must be submitted by the PHN to the School Health Aide at the school, and maintained on file in the school health room.
7. In order for medications to be stored and administered in school, the medications must:
   a. Be dispensed by a pharmacist in accordance with HRS §328-16 (a)(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 or other practitioner with prescribing authority. The instructions on the container must state, **“FOR SCHOOL USE;”** and
   d. Be designated on a completed Form SH36.
8. Parent/legal guardian is responsible for providing an appropriately labeled supply of medications and a recent photo of their child to the health room at school. This should be coordinated with the school health aide, the child's teacher(s), and the school principal. Medications that are discontinued or unused must be picked up by the parent/legal guardian.
9. Should there be any new medication order(s) by the physician or other practitioner with prescribing authority, a new “Request to Store and Administer Emergency Rescue Medications and Daily, Routine, Scheduled Medications, As Applicable” (SH36, Revised 2021) must be completed and submitted as specified in this form. The form may be sent to school with the new container/vial of medication to reflect the new order(s) using the process specified on this form. Prescription refills based on the prescription on file do not require a new form.
10. If your child is off campus during the regular school day to participate in a DOE sponsored activity, prior arrangements must be made between the parent/legal guardian and the school in order for your child to be able to receive scheduled medications. Otherwise, your child will **NOT** be able to receive the scheduled medication for the day.
11. **This form is applicable only for the current school year and must be renewed yearly.**
    Parent/legal guardian are responsible for submitting requests for the following school year