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 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 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**.

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: _____

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 prescribed over-the-counter medications.
3. I/We also understand that any changes in medication or dosage must be in writing and signed by the prescribing health care provider.
4. 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.

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

Section II. Medication Information from Prescribing Healthcare Provider

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.

_____ _____
Medical Director or Designee | Date