



Request for Administration/Storage of Medication in School

Return form to: HPA Health Services, 65-1692 Kohala Mountain Road, Kamuela, Hawai'i 96743 -or- Fax: 808-881-4045

INSTRUCTIONS

Students who take medication while at school are required to inform the school's health services staff. The school nurses supervise the administration of medication in school. A student taking medication on a regular basis is required to have in his/her health file an evaluation by a physician, which provides a diagnosis, the name of the medication, and a treatment plan. Any changes in medication or dosage must be ordered by a physician. A permission form signed by the student's parent or guardian authorizing the administration of medication by health services staff and/or the self-administration of medication by the student is required to be on file. **A separate form must be completed for each medication. A new form must be completed and submitted at the beginning of each school year.**

Student name: _____ Date of birth: _____ Grade: _____

PARENT/GUARDIAN INFORMATION

Parent 1: _____ Relationship to Student: _____

Phone 1: _____ Phone 2: _____ Phone 3: _____

Parent 2: _____ Relationship to Student: _____

Phone 1: _____ Phone 2: _____ Phone 3: _____

Student lives with (check all that apply): Parent 1 Parent 2 Both Parents

MEDICATION/INSTRUCTIONS

Name of medication: _____ Dosage: _____

Specific diagnosis for which this medication is prescribed: _____

Date to begin administration of above medication: _____

Continue administering medication as described above until: _____

Please note here any behavioral, physical, and/or emotional changes that should be monitored while the student is on this medication: _____

PRESCRIBING PHYSICIAN

Physician's name: _____ Phone: _____

Address: _____ Fax: _____

If the prescribing physician is out of state, please provide the contact information for a local physician/counselor:

Physician's name: _____ Phone: _____

Address: _____ Fax: _____

AUTHORIZATION

- I, the undersigned, request and authorize Hawai'i Preparatory Academy health services staff, or persons they designate, to administer to my child and store the medication described above.
- I, the undersigned, authorize the release of information pertinent to my child's condition related to the medication described above between Hawai'i Preparatory Academy personnel and the prescribing physician.
- I, the undersigned, will complete and submit a new Request for Administration/Storage of Medication in School form should there be any change in the administration of medication described above or physician's orders.

Signature of Parent 1: _____ Date: _____

Printed Name of Parent 1: _____

Signature of Parent 2: _____ Date: _____

Printed Name of Parent 2: _____

FOR HPA USE: Received by: _____ Date: _____ Logged by: _____ [original to HS]