STATE OF HAWAII

DEPARTMENT OF EDUCATION

REQUEST TO STORE AND ADMINISTER MEDICATIONS

School: ____ School Year: _______________

Please complete this form in black or blue ink

Student Name (Last, First):			Date of Birth:
Home Address:			Grade/Rm #:
Parent/Legal Guardian Name:	Cell:	Work:	Home:
Parent/Legal Guardian Name:	Cell:	Work:	Home:
Medical Insurance: ☐ Medicaid (QUEST) ☐ Tricare ☐ HMSA-Private ☐ Kaiser-Private ☐ None ☐ Other: _______________			

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

Request and Authorization:

I, the undersigned, request and authorize the following individuals to administer medication to my child as specified in medication orders on this form prescribed by my child's physician or other practitioner with prescribing authority: personnel of the Hawaii Department of Education (DOE), and their employees or agents, including nurses and their supervised delegates assigned by the DOE pursuant to written agreement.

I request and authorize the DOE to release education records of the above named student pursuant to this request, including health information, to the prescribing physician or other practitioner with prescriptive authority completing this form, the dispensing pharmacist, and as applicable to the Hawaii State Department of Health (DOH) Public Health Nurse (PHN). I understand that a separate release of information request may be required by my physician or other health care provider to facilitate this request.

Waiver of Liability:

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 medications specified on this form.

My initials and signature below indicate that:

__________ (initials) I consent to the policy and procedures set forth on page 2 of this form, "Notice to Parents/Legal Guardians and Healthcare Providers;"

__________ (initials) I agree to follow the instructions on page 2 of this form, "Notice to Parents/Legal Guardians and Healthcare Providers;"

__________ (initials) I understand and agree I am responsible for providing appropriately labeled medications and a recent photograph of my child in accordance with the instructions on page 2 of this form;

__________ (initials) I understand and agree that the medication may be administered by unlicensed personnel who have received training for safe medication administration as permitted under Hawaii Revised Statutes, §302A-853 and §457;

Parent/Legal Guardian Signature:	Parent/Legal Guardian Printed Name:	Date:

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

Please note: School Health Assistants (SHA) are not licensed health professionals but are specifically trained in medication administration under predictable circumstances. They are not able to perform clinical assessments which may be necessary to determine the need for medication or response to medication. They are provided with protocols to follow in situations where the need for medication is explicit, straightforward and can be strictly defined.

1. This form represents my consent and request for the medication services described on this form. It is not an agreement by Hawaii DOE to provide the requested services. Only medications that have been approved pursuant to this form may be stored in the school.
2. Medications should be given at home when possible. Scheduled medications may be requested to be given during the school day when the prescribing physician or other practitioner with prescriptive authority provides attestation that this request is necessary for the health and safety of the student to attend school.
3. Antibiotics, analgesics, and over-the-counter medications **are not permitted** to be stored or administered at school.
4. **Unscheduled, "as needed" or "pro re nata (PRN)" medications will only be approved to be stored and administered during the school day when availability of the medication is necessary for the health and safety of a student due to a chronic medical condition or eligible disability.**
5. Certain emergency rescue medications may be administered by unlicensed personnel such as a SHA, in accordance with Hawaii Revised Statutes (HRS) §302A-853, 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.
    a. Epinephrine 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.
    b. Asthma quick-relief inhalers and emergency seizure medications: When administered by unlicensed personnel, the school will notify the parent/legal guardian to pick up the student. 911 may be called in cases required by the student's condition or if indicated by the student's individual Emergency Action Plan. In cases where a registered nurse (RN) is available to assess the student, the RN may determine that the student could otherwise safely remain in school. Parent/legal guardian will be notified of the RN's assessment.
6. No student-specific medications will be administered by the authorized DOE employees or agents without the completion and approval of this SH36 form which includes the following requirements:
    a. Parent/legal guardian must complete and sign 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(a) and/or II(b), PHYSICIAN'S or PRACTITIONER WITH PRESCRIPTIVE AUTHORITY'S REQUESTED ORDERS;
    c. Section III(a) and/or III(b), AUTHORIZED HEALTH CARE PROFESSIONAL APPROVAL OF REQUESTED MEDICATION ORDERS, must be completed by a health care professional (as defined by HRS §302A-853) indicating approval of the request on the same page as the corresponding orders in section II(a) and/or II(b); and
    d. The completed and approved form must be submitted to the school and maintained on file in the student's record.
7. In order for medications to be stored in school and administered by the DOE SHA, the medications must:
    a. Be dispensed by a pharmacist in accordance with HRS §328-16(a)(1)-(11). This includes container/vial labeling with the name of the student, name of the medication, strength and instructions for use of the medication, and name of the prescribing physician or other practitioner with prescriptive authority;
    b. The instructions on the container must be consistent with a completed Form SH36 or SH36DM; and
    c. Be designated on a completed and approved Form SH36 or SH36DM.
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 assistant, 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. In cases where a student with approved SH36 medication(s) is off campus to participate in a DOE sponsored activity, prior arrangements must be made between the parent/legal guardian and the school to ensure the student will receive these medications.
10. Any new medication order(s) or changes to a previously approved SH36 form, will require a new "Request to Store and Administer Medications" form (SH36, Revised 2024) to be completed and approved as specified in this form. However, prescription refills for an approved SH36 medication request do not require a new form.
11. This form is applicable only for the current school year and must be renewed yearly. Parent/legal guardian is responsible for submitting requests for the following school year.

Student's Name: ____ Date of Birth: ________________

II(a). PHYSICIAN'S or PRACTITIONER WITH PRESCRIPTIVE AUTHORITY'S REQUESTED ORDERS

Diagnosis: ____ ICD-10: __________ Weight (kg): ___________

Allergies: ____

<table>
<tr><th colspan="5">EMERGENCY RESCUE MEDICATIONS</th></tr>
<tr><th></th><th>Name/Dosage/Route</th><th>Frequency (timing)</th><th>Indications for use</th><th>Actions</th></tr>
<tr><td>Anaphylaxis</td><td>☐ Epinephrine Auto-injector, premeasured dose of 0.15 mg, IM [15-30 kg (33-66 pounds)]

☐ Epinephrine Auto-injector, premeasured dose of 0.3 mg, IM [≥30 kg (≥66 pounds)]</td><td>Give one dose: immediately upon onset of life-threatening symptoms

Repeat dose: One time after 5 minutes if life-threatening symptoms persist</td><td>Life-threatening symptoms: (any one or more)
☐ Difficulty breathing, shortness of breath
☐ Difficulty swallowing, itching, tightness, and/or swelling in throat
☐ Hives all over body
☐ Nausea/vomiting, abdominal pain
☐ Light-headedness, fainting, decreased level of consciousness
☐ Other: ___________________________</td><td>Call 911 immediately on recognizing life-threatening symptoms and notify parent/legal guardian.

☐ Additional instructions:</td></tr>
<tr><td>Asthma</td><td>☐ Albuterol MDI (90 mcg/puff)

☐ Levalbuterol MDI (45 mcg/puff)

Dose to be given:

__________# of puffs, inhalation
(Please DO NOT prescribe a range of puffs such 4-6)

☐ Use with spacer and/or facemask, if available (will need to be prescribed one for school)</td><td>Give one dose: immediately upon onset of asthma symptoms

Repeat dose: One time after 15 minutes if asthma symptoms persist</td><td>Asthma symptoms: (any one or more)
☐ Shortness of breath
☐ Chest tightness
☐ Wheezing
☐ Persistent coughing
☐ Difficulty breathing
☐ Other:
____
☐ Other:
_________________________________</td><td>Call 911 if persistent life-threatening symptoms, or otherwise indicated in student's Emergency Action Plan and notify parent/legal guardian

☐ Additional instructions:</td></tr>
<tr><td>Seizures</td><td>☐ Valtoco (diazepam), dose to be given: _____mg, intranasal

☐ Nayzilam (midazolam), 5 mg, intranasal

☐ Other Medication:

Name:______________________

Dose to be given:_____________

Route to be administered:______</td><td>Give one dose for:
☐ Generalized convulsive seizure lasting >5 minutes

☐ Episodes lasting >10 minutes of multiple seizures without recovery of consciousness

☐ Other seizure symptoms lasting

______ minutes</td><td>Generalized convulsive (tonic-clonic) seizure includes:
Loss of consciousness, stiffening or muscle rigidity progressing to jerking or rhythmic muscle movements, irregular pattern or pause in breathing

Other Seizure Symptoms:
☐ Must include impaired awareness or loss of consciousness
☐ May include (any one or more):</td><td>Call 911 if persistent seizure or life-threatening symptoms, or otherwise indicated on student's Emergency Action Plan and notify parent/legal guardian

☐ Additional instructions:</td></tr>
<tr><td colspan="5">The above indicated medication(s) is/are necessary for the health of the student and for the student's attendance at school/school related functions
☐ Yes ☐ No</td></tr>
</table>

Physician/Practitioner (Please stamp or print legibly) Phone: Fax:

Name:

Address:

Signature: _________________________________ Date: ___________

III(a). AUTHORIZED HEALTH CARE PROFESSIONAL APPROVAL OF REQUESTED MEDICATION ORDERS

Review completed by the following health care professional within the DOE, DOH, or a health care service pursuant to written agreement with DOE:	Administration of medication to the above named student as requested by the parent/legal guardian and prescribed above by the physician/practitioner:
See consultation report for complete details. Name: Signature: ______________________ Date: _________	☐ is approved for administration by School Health Assistant (SHA) ☐ is recommended for Skilled Nursing Services (SNS) ☐ is not approved for administration in the school setting Additional Comments:

Student's Name: ____ Date of Birth: ________________

II(b). PHYSICIAN'S or PRACTITIONER WITH PRESCRIPTIVE AUTHORITY'S REQUESTED ORDERS

Diagnosis: ____ ICD-10: __________ Weight (kg): ___________

Allergies: ____

DAILY, ROUTINE, SCHEDULED MEDICATIONS

Name/Dosage/Route	Frequency (timing)	Reason medication needed during the school day:
Medication Name:__________________________ Dose to be given: _________________ Route to be administered:___________	Frequency medication is given: _______________ Specific time(s) to be given during school: _______________	The indicated medication is necessary for the health of the student and for the student's attendance at school/school related functions: ☐ Yes ☐ No Additional Comments:
Medication Name:__________________________ Dose to be given: _________________ Route to be administered:___________	Frequency medication is given: _______________ Specific time(s) to be given during school: _______________	The indicated medication is necessary for the health of the student and for the student's attendance at school/school related functions: ☐ Yes ☐ No Additional Comments:

OTHER REQUESTED EMERGENCY AS NEEDED (PRN) MEDICATIONS

Please note: Unscheduled, "as needed" or "pro re nata (PRN)" medications will only be approved to be stored and administered during the school day when availability of the medication is necessary for the health and safety of a student due to a chronic medical condition or eligible disability.

Name/Dosage/Route	Frequency (timing)	Indications for use	Actions
Medication Name:__________________________ Dose to be given: _________________ Route to be administered:___________	Frequency medication is given: ________________	Description of Symptoms (Specific circumstances where medication may be given):	☐ Additional instructions:
Reason medication needed during the school day:			
Medication Name:__________________________ Dose to be given: _________________ Route to be administered:___________	Frequency medication is given: ________________	Description of Symptoms (Specific circumstances where medication may be given):	☐ Additional instructions:
Reason medication needed during the school day:			

Physician/Practitioner (Please stamp or print legibly)

Name:

Phone: Fax:

Address:

Signature: ________________________________ Date: ___________

III(b). AUTHORIZED HEALTH CARE PROFESSIONAL APPROVAL OF REQUESTED MEDICATION ORDERS

Review completed by the following health care professional within the DOE, DOH, or a health care service pursuant to written agreement with DOE: See consultation report for complete details. Name: Signature: _____________________ Date: _________	Administration of medication to the above named student as requested by the parent/legal guardian and prescribed above by the physician/practitioner: ☐ is approved for administration by School Health Assistant (SHA) ☐ is recommended for Skilled Nursing Services (SNS) ☐ is not approved for administration in the school setting Additional Comments: