

REQUEST FOR ADMINISTRATION / STORAGE OF MEDICATION
AT Pearl Harbor Christian Academy (PHCA) FOR _____ - _____ YEAR

Please complete form in ink.

CHILD'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM:	BUS. PHONE:
ADDRESS:	ZIP CODE:	HOME PHONE:	Mother:
Please check () child's health insurance plan: QUEST ___ MEDICAID ___ CHAMPUS ___ HMSA-Private ___ KAISER-Private ___			Father:
OTHER (specify) _____			NONE ___

I. PARENT'S REQUEST AND AUTHORIZATION

I, the undersigned, request and authorize **Pearl Harbor Christian Academy (PHCA)** personnel to administer/store medication as prescribed by my child's physician. I request and authorize release of health information between the school, the Public Health Nurse, the prescribing physician, and pharmacist pertinent to my child's condition. I understand that a new request is to be processed should there be any change in medication.

PARENT'S/ LEGAL GUARDIAN NAME: _____ (type/print)	PARENT'S/ LEGAL GUARDIAN SIGNATURE: _____ DATE: _____
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II. PHYSICIAN'S REQUEST

DIAGNOSIS: _____ WEIGHT: _____

Medication Allergies: _____

POLICY: Medications for chronic illnesses and/or life threatening conditions shall be administered during the school day. An order for other medications requires reason(s) for its administration during the school day.

SCHEDULED MEDICATIONS FOR CHRONIC ILLNESS AND/OR LIFE THREATENING CONDITION:

MEDICATION Name/Dosage	EXACT TIME OR RANGE OF TIME TO BE GIVEN	SPECIAL INSTRUCTIONS	DURATION OF TREATMENT

PRN MEDICATION:

MEDICATION Name/Dosage	SPECIFIC INDICATIONS FOR USE	REASON(S) WHY PRN MEDICATION IS NEEDED IN SCHOOL (REQUIRED RESPONSE)

Physician's Signature: _____

DATE: _____

Physician's Name: _____
(type/print)

ADDRESS: _____

Telephone: _____ FAX: _____

<p>PHCA SCHOOL OFFICE AUTHORIZATION</p> <p><i>This form must be approved and signed by PHCA Office Personnel in order for meds to be administered at school.</i></p> <p>_____</p> <p>DATE</p>
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INSTRUCTIONS FOR REQUEST FOR ADMINISTRATION/STORAGE OF MEDICATION IN SCHOOL

GENERAL INSTRUCTIONS:

1. Medications for chronic illnesses and/or life threatening conditions shall be administered during the school day. Medications should be given at home as much as possible.
2. Antibiotics will not be administered unless there are no other alternatives and physician provides reasons why it must be administered during the school day.
3. Over the counter medications will not be administered unless the physician provides reasons why it must be administered during the school day.
4. **No medication will be stored in the Health Room or administered by the authorized school personnel without the completion of this form and authorization by the school office.**
 - a. Parent/Legal Guardian must complete Section I, Parent's Request and Authorization.
 - b. Physician must complete Section II, Physician's Request.
 - c. Parent/Legal Guardian is to return this completed form to the PHCA School office for approval.
5. Medication must be in a container/vial dispensed by the Pharmacist with instructions **"FOR SCHOOL USE"** with the name of the student, name of the medication, dosage, strength, time of administration, and name of prescribing physician.
6. Parent/Legal Guardian is responsible to send medications to Health Room at school. If there are concerns in getting the medication to the health room safely, parents should call the office. Parent/legal guardian is to:
 - a. Send the container/vial of medication labeled **"FOR SCHOOL USE."** Medication(s) will only be accepted if medication is in the container/vial labeled by the Pharmacist is the same as requested by your child's physician.
your child's physician.
 - b. Send in refills in a timely manner in properly labeled container/vial before medication runs out.
 - c). Remind your child to report to the school office when they need their meds.
7. Should there be any change in medication order(s) by the physician, a new "Request for Administration/Storage of Medication in School" (PHN/SH 36 Rev. 3/03) must be processed. The form should be sent to school with a new container/vial of medication to reflect the new order(s).
8. If the Public Health Nursing personnel/ School Health Aide are not on duty or if your child is off campus, **NO MEDICATION WILL BE GIVEN FOR THAT DAY unless prior arrangement has been made between parent/legal guardian and school.**
9. This form is good for the current school year and needs to be renewed yearly. Parent/legal guardian is responsible to obtain the form for the following school year.

Waiver of Liability:

NOTICE: PHCA administration 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 PHCA Administration and their employees or agents, including nurses assigned by the PHCA 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: _____