Honolulu Waldorf School

ADMINISTRATION/STORAGE OF MEDICATION 2016-17

Occasionally, in emergency situations or when dosages must be scheduled during the school day, it is necessary for oral or topical prescribed medication to be administered at school. **No medication will be either stored at the school or administered by authorized school personnel without the prior authorization of the child's parent/legal guardian and physician as evidenced by this completed form**.

Please follow these instructions:

1. PARENT/GUARDIAN must complete SECTION I.
2. PHYSICIAN must complete SECTION II.
3. When SECTIONS I & II have been completed, PARENT is to return this form to the Honolulu Waldorf School Office.

Upon approval of this request, PARENT/GUARDIAN is to:

a. Bring to the school office the medication in a container labeled by the pharmacist to include:

   Name of child
   Name of medication
   Dosage
   Time to be given
   Name of prescribing physician

b. Daily Medication
   Supply only the amount of medication required for one school week.
   Container will be returned on the last day of each school week.

c. Emergency Medication
   Supply only the amount necessary for three dosages if in tablet form or no more than 30 cc if in liquid form.

d. Supply a measuring spoon to accompany liquid medication.

e. Remind child to report to the Class Teacher at designated time.

Please remember that no medication will be stored at the school or administered by authorized school personnel without the prior completion of this form.

The "Administration/Storage of Prescribed Medication" form must be completed and filed each school year and whenever the prescription is changed, even as to dosage amount, by the Physician.

Jocelyn Romero Demirbag
Administrative Director

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REQUEST FOR ADMINISTRATION/STORAGE OF MEDICATION IN SCHOOL 2016-17

(Please complete form in ink.)

Child's First Name: ________________________________ Last Name: ______________________________________

Date of Birth: ________________________ Grade: ________ Early Childhood: ❑ Kukui ❑ Koa ❑ Milo ❑ Kamani

Parent 1 Full Name: ____ Res. Phone: _______________________

Cel: ______________________ Business Tel: ______________________ Email: ______________________________

Parent 2 Full Name: ____ Res. Phone: _______________________

Cel: ______________________ Business Tel: ______________________ Email: ______________________________

Child Resides with: ❑ Both Parents ❑ Parent 1 ❑ Parent 2

Child's Address: ____

City ____________________________ State: ____________ Zip Code: ______________

I. PARENT'S/GUARDIAN'S REQUEST AND AUTHORIZATION

I, the undersigned, request and authorize the qualified school personnel to administer/store medication as prescribed by my child's physician to my child ______________________________________. I request and authorize release of information between the school, authorized personnel, and the prescribing physician pertinent to my child's condition.

I understand that a new request is to be processed should there be any change in medication or physician's orders.

_____________________________________ _____________________________________ ________________

Parent/Guardian PRINT FULL NAME **Parent/Guardian SIGNATURE** **Date**

II. PHYSICIAN'S REQUEST

CHILD'S FULL NAME: (PRINT): ____

DIAGNOSIS: ____

Medication Order (Name and Dosage)	Time To Be Given In School	Special Instructions Including Method of Administration	Potential| Reactions to Medication

Medication Allergies: ____

Other Medication Currently Being Taken: ____

PHYSICIAN'S NAME: ____ PHYSICIAN'S SIGNATURE: ______________________________

ADDRESS: ____

TELEPHONE: _______________________________________ EMAIL: ____________________________________

DATE: _______________________________