HONOLULU WALDORF SCHOOL
KULA HOʻOMOHALA PUA

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ADMINISTRATION / STORAGE OF MEDICATION

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. (Email niu@honoluluwaldorf.org)

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

1. Bring to the school office the medication in a container labeled by the pharmacist. It must include:
    1. Name of child
    2. Name of medication
    3. Dosage
    4. Time to be given
    5. Name of prescribing physician

2. Daily Medication
    1. Supply only the amount of medication required for one school week. Container will be returned on the last day of each school week
    2. Emergency Medication
    3. Supply only the amount necessary for three dosages if in tablet form or no more than 30 cc if in liquid form
    4. Supply a measuring spoon to accompany liquid medication
    5. 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.

Mahalo,

Honolulu Waldorf School

REQUEST FOR ADMINISTRATION/STORAGE OF MEDICATION IN SCHOOL

(Please complete form in blue or black ink)

Child's First Name:_____ Last Name: _____

Date of Birth:_____ Grade/Class: _____

Parent 1 Full Name:_____ Res. Phone:_____

Mobile:_____ Business Tel:_____ Email: _____

Parent 2 Full Name:_____ Res. Phone:_____

Mobile:_____ Business Tel:_____ Email: _____

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

Child's Address:_____

City_____ State:_____ Zip Code: _____

SECTION 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

SECTION 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:_____ SIGNATURE:_____

ADDRESS: _____

TELEPHONE:_____ EMAIL: _____

DATE: _____