KAMEHAMEHA SCHOOLS
MĀLAMA OLA HEALTH SERVICES DEPARTMENT

REQUEST FOR ADMINISTRATION OF MEDICATION

(One medication per form)

Student's Name: _____ _____
Last First

Date of Birth: ____/____/_____ Grade Entering: _____ Student ID: _____

Section I. Agreement and Release by Parent/Legal Guardian(s)

1. I/We, the undersigned, request and authorize Kamehameha Schools Health Services staff or their designee to administer medication, as prescribed by his/her health care provider, to my/our child named above.
2. I/We understand that this request pertains to prescription medications as well as regularly used prescribed over-the-counter medications.
3. I/We also understand that any changes in medication or dosage must be in writing and signed by the prescribing health care provider.
4. I/We hereby release and agree to indemnify, defend and hold forever harmless the Kamehameha Schools, its trustees, representatives, agents and employees from and against any and all claims arising from personal injury and/or property damage resulting from the administration of medication consistent with this request.

_____ _____ _____
Signature of Parent/Legal Guardian Printed Name of Parent/Legal Guardian Date

Section II. Medication Information from Prescribing Healthcare Provider

Diagnosis: _____ Medication name/dose: _____

Directions for use: _____

Medication to be administered until: _____/_____/_____ OR ☐ End of Current School Year

Name of Physician_____ Phone_____

Address_____

Signature of Physician_____ Date_____

Office Use Only

The above request has been reviewed and the medication will be administered at school as requested.

_____ _____
Medical Director or Designee Date