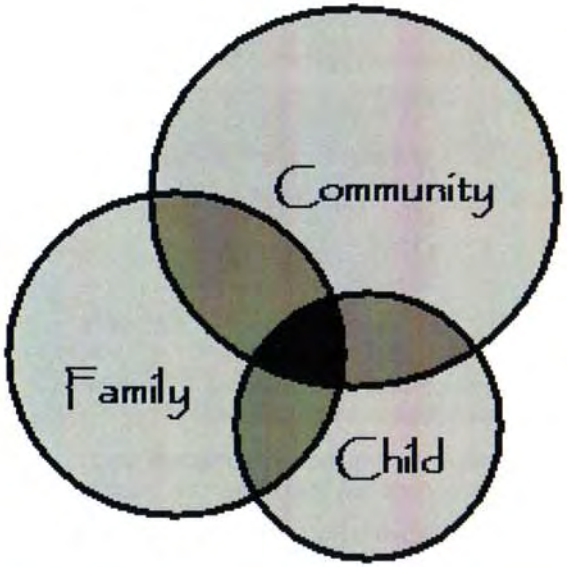
Ask us!



....for Healthier Tomorrows!

Please Call:

OAHU PHN Offices in your Community:

East Honolulu—733-9220
West Honolulu—832-5757
Central Oahu—453-6190
Leeward Oahu—675-0073
Windward Oahu—233-5450

Neighbor Island Offices:

East Hawaii—974-6025
West Hawaii—322-1500
Maui —984-8260
Kauai —241-3387
Molokai —553-3663
Lanai —565-7114

Public Health Nursing Branch
1250 Punchbowl Street
Honolulu, Hawaii 96813

586-4620

Nondiscrimination in Services
We provide access to our activities without regard to race, color, national origin (including language), age, sex, religion, or disability. Write or call the Public Health Nursing Branch or our departmental Affirmative Action Officer at P.O. Box 3378, Honolulu, HI, 96801-3378 or at (808) 586-4616 (voice/tty) within 180 days of problem.

4/2003

Need Help?

Public Health Nursing

...at work in your Community!

Public Health Nursing Services

Community Based,

Family *Centered, &*

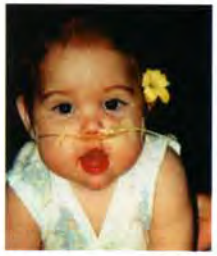
Individualized

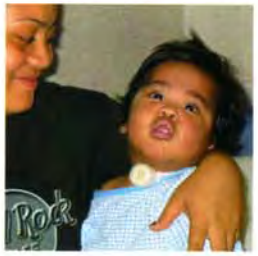
- **Health Assessment**
- **Care Coordination**
- **Development of Individualized Family Support Plan (IFSP)**
- **Transition Planning**
- **Linkages with Resources**

Assisting Individuals and Families

Individuals and families with barriers to health care

Assist accessing health care, medical resources & insurance





Infants, toddlers and school age children with chronic and/ or complex medical conditions

Coordinate health and other related services to maintain living in the home and community

Assist with integrating health and educational services. Develop Emergency Action Plans.

High-risk pregnant women

Assist in accessing prenatal care, medical resources & insurance

Frail dependent elderly

Coordination of health and other services to maintain living in the home and community

Assisting the Community

Control of Communicable Diseases

Tuberculosis screening and follow up

Immunization services for 0-18 years old

Hansen's Disease outreach Outbreaks and epidemic assistance

Health Services in Public Schools

Provision of first aid services & medication administration by health aides

Consultation on students' medical and health conditions that impact on learning

Skilled Nursing Services to students' with special needs

Disaster Response to communities affected by disasters

Partnership with Community to address health needs of a community

General Overview of Public Health Nursing Branch (PHNB)

Public Health Nursing Branch is the branch under Community Health Division, Health Resources Administration within the Department of Health. PHNB administers the public health nursing services through the Public Health Nursing Sections, statewide. The staff of PHNB is made up of Public Health Nurses, who are Registered Nurses, Licensed Practical Nurses, Para-medical Assistants, Health Aides in the public schools, and clerical support staff.

Public Health Nursing services are focused on public health issues such as, but not limited to:

SERVICES	TARGET POPULATION
Immediate mobilization of services during disasters, epidemics, other biologic threats	General population impacted during event
Control of communicable diseases through contact and source investigations for tuberculosis, Hansen's Disease	Clients suspected/diagnosed with tuberculosis, Hansen's Disease, or other communicable diseases
Immunization services through immunization clinics and follow-up; facilitate access to medical home and health insurance program	Children with no health insurance or having difficulty accessing the health care system; children behind with immunizations
School Health Services provided through health aides: first aid, injury care, administration of medications. Consultation services to DOE personnel regarding students with health/medical concerns	Students in the public schools served by the health aide; Public Health Nurses assigned to specific publics schools work with the principal and other DOE personnel
School Health Services: Specialized health care procedures(i.e. suctioning, gastrostomy feeding, etc.) administered by licensed practical nurses	Eligible students under Individual Disabilities Education Act (IDEA), Part B
Care Coordination Services to infants and toddlers for Early Intervention Services	Infants and toddlers (birth to age 3) with complex medical conditions or considered medically fragile, under IDEA, Part C.
Care Coordination services to special needs population with medical/health conditions to facilitate access to services and support caregivers	Special needs children with no/limited access to health care and/or those at risk for developmental delays or negative health status related to risk factors as abuse/neglect; substance use, domestic violence, and parental challenges that impact on young children; Frail vulnerable elderly; high risk pregnant women.
Other groups to facilitate access to services	Homeless; Immigrants
Working in collaboration with community	Specific to community needs

Public Health Nursing
1250 Punchbowl Street
Honolulu, HI 96813
(808) 586-4620

From: Hawaii Department of Health
www.hawaii.gov/health/family-child-health/publichealthnursing/index.html

Public Health Nursing Sections Statewide

Public Health Nursing Branch 1250 Punchbowl Street, Rm 210 Honolulu, Hawaii 96813	Ruth Ota Branch Chief	Phone: (808) 586-4620 Fax:(808)586-8165 rkota@mail.health.state.hi.us
East Honolulu PHN Section 3627 Kilauea Avenue, Rm 311 Honolulu, Hawaii 96816	Charlene Ono Supervisor	Phone: (808) 733-9220 Fax: (808) 733-9375 ceono@camhmis. health, state, hi. us
West Honolulu PHN Section 1700 Lanakila Avenue, Rm 201 Honolulu, Hawaii 96817	Lily Ochoco Supervisor	Phone: (808) 832-5757 Fax: (808) 832-5742 lkochoco@mail.health.state.hi.us
Central Oahu PHN Section 860 Fourth Street, Rm 130 Pearl City, Hawaii 96782	Susan Fujii Supervisor	Phone:(808)453-6190 Fax: (808) 453-6777 ssfujii@mail.health.state.hi.us
Leeward Oahu PHN Section 94-275 Mokuola Street, Rm 101 Waipahu, Hawaii 96797	Jane Yoshimura Supervisor	Phone:(808) 675-0073 Fax: (808) 675-0079 jnyoshim@mail. health, state, hi. us
Windward Oahu PHN Section 45-691 Keaahala Road Kaneohe, Hawaii 96744	Agnes Pigao Cadiz Supervisor	Phone: (808) 233-5450 Fax: (808) 233-5303 aepigaoc@mail. health, state, hi. us
East Hawaii PHN Section 75 Aupuni Street Hilo, Hawaii 96720	Judith Akamine Supervisor	Phone: (808) 974-6025 Fax: (808) 974-6000 jyakamin@mail.health.state.hi.us
West Hawaii PHN Section P. O. Box 228 79-1015 Haukapila Street Kealakekua, Hawaii 96750	Deborah Wiley Assistant Supervisor	Phone:(808)322-1500 Fax:(808)322-1504 dawiley@mail.health.state.hi.us
Kauai PHN Section 3040 Umi Street Lihue, Hawaii 96766	Joyce Chuang Supervisor	Phone:(808)241-3387 Fax:(808)241-3480 jgchuang@mail.health.state.hi.us
Maui PHN Section 54 High Street, Rm 301 Wailuku, Hawaii 96793	Lizbeth Olsten Supervisor	Phone (808) 984-8260 Fax:(808)243-5118 lrolsten@mail. health, state, hi. us
Molokai PHN Office P. O. Box 2007 Kaunakakai, Hawaii 96748	Jim Callahan PHN	Phone: (808) 553-3663 Fax: (808) 553-9845
Lanai PHN Office P.O. Box 763 Lanai City, Hawaii 96763	Jacqueline Woolsey PHN	Phone:(808)565-7114 Fax:(808)565-7918

* Molokai and Lanai under Maui PHN Section

State of Hawaii
Health Department

Public Health
Nursing Branch

REQUEST FOR NURSING SERVICES

DATE:_____

CLIENT: _____ SEX:___ BD:___/___/___ School / Gr:_____
Last First

_____ SEX:___ BD:___/___/___ School / Gr: _____

_____ SEX:___ BD:___/___/___ School / Gr: _____

ADDRESS: _____ **APT. NO.**_____ **HOME PHONE:** _____

Mailing address (if different): _____

FATHER: _____ BD:___/___/___ Phone:_____
(Man) Last First if different work
other

MOTHER: _____ BD:___/___/___ Phone:_____
(Woman) Last First if different work
other

Other Contact Person / Phone: _____

MEDICAL INSURANCE & NUMBER: _____

PHYSICIAN / PCP: _____

Medical/Clinical Diagnosis:_____

REASON(S) FOR REFERRAL _____

_____

_____

SIGNIFICANT INFORMATION _____

_____

_____

_____

_____

PLANNED DISCHARGE DATE: _____ HOSPITAL: _____

OTHER AGENCIES INVOLVED OR REFERRED TO: CONTACT PERSON & PHONE NUMBER:

_____ _____

_____ _____

REQUESTED BY: _____ Title: _____ Agency: _____

ADDRESS: _____ **Phone:** _____

****

PHN SUMMARY:_____

_____

_____

_____

For PHN Office Use Only:
Date Rcvd: _____ By: _____ CT /Assigned PHN: _____

Currently Carried ☐ No ☐ Yes By_____Previously Carried by_____Registration#_____
QA_____ Live_____

DISPOSITION: ☐ Admitted ☐ Disposition Letter Sent; Date_____ Not admitted date:_____
☐ L Unlocated ☐ R Refused PHN services ☐ C Assistance from Other Agency/Program ☐_____

Department of Education
STUDENT'S HEALTH RECORD

Name _____ (Last) _____ (First) _____ (Middle Initial)

Birthdate ☐☐ Month ☐☐ Day ☐☐☐☐ Year

Parent's Name _____ (Mother/Guardian) _____ (Father/Guardian)

Female ❑ Male ❑

Preschool: Entry Date ___/___/___
Elementary: Entry Date ___/___/___
Intermediate/Middle: Entry Date ___/___/___
High: Entry Date ___/___/___

Student Address Label

Please complete the following sections **(CHECK IF YES)**

MEDICAL STATUS

Allergy (type)	❑	Cancer/Leukemia	❑	Hearing Problems	❑	Rheumatic Heart	❑
Asthma	❑	Chronic Cough/Wheezing	❑	Heart Disease	❑	Sickle Cell Anemia	❑
Vision Problems	❑	Diabetes	❑	Hemophilia	❑	Seizures	❑

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

Date	Grade	Height	Weight	Blood Pressure	Vision R.	Vision L.	Hearing R.	Hearing L.	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Significant Findings and Recommendations	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
/ /																							/ /				
/ /																							/ /				
/ /																							/ /				
/ /																							/ /				

TUBERCULOSIS EXAMINATION
MANTOUX TEST (INTRADERMAL)

Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)	Y*	N*
/ /	/ /			❑	❑
/ /	/ /			❑	❑
/ /	/ /			❑	❑

CHEST X-RAY

Date	Results	Location		
			❑	❑
			❑	❑

DENTAL EXAMINATION

Dental Check-Up	/ /	❑	❑

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)

DTaP, DTP, DT, or Td		Polio (IPV or OPV)		HIB *Haemophilus Influenzae* type B		Hepatitis B	Varicella	MMR	Y*	N*
Type	Date Given	Type	Date Given	Type	Date Given	Date Given	Date Given	Date Given		
	/ /		/ /		/ /	/ /	/ /	/ /	DTaP	❑ ❑
	/ /		/ /		/ /	/ /	/ /	/ /	Polio	❑ ❑
	/ /		/ /		/ /	/ /	/ /	/ /	HIB	❑ ❑
	/ /		/ /		/ /	/ /	/ /	/ /	HEP	❑ ❑
	/ /	OTHER						Measles	MMR	❑ ❑
	/ /	Type	Date Given	Date Given		Date Given		/ /	Varicella	❑ ❑
	/ /		/ /	/ /		/ /		Mumps / /		
	/ /		/ /	/ /		/ /		Rubella / /		

Physician, APRN, PA or Clinic _____
(Signature or stamp if different from above)

***OFFICE USE ONLY** (Rev. 2002)

Health History/Comments: Include Referrals and Reports. Recommendation for significant findings.
(Please Print.)

Date		Signature & Title	Date		Signature & Title

POLICIES AND GUIDELINES FOR REQUEST FOR ADMINISTRATION/STORAGE OF MEDICATION IN SCHOOL

1. Medication(s) ordered for chronic illnesses and/or life threatening conditions shall be accepted for administration at school.
2. Order for antibiotics will NOT be accepted unless there are no other alternatives. Reasons why it must be administered in school must be included.
3. Order for over the counter medications will NOT be accepted unless the order is accompanied with reasons why it must be administered in school.
4. Administration of medication at school mandates the written order on Form PHN/SHS 36, "Request for Medication/Storage of Medication," with parental approval signified by signature and dated. No medication will be administered by school health aide, PHN, or DOE staff without the proper completion of the Form PHN/SHS 36.
5. Medication must be dispensed as stipulated in Hawaii Revised Statutes HRS 328-16 with label bearing the following: Name, business address, telephone of the seller, name of person for whom drug was prescribed, serial number of prescription, date the prescription was prepared, name of the practitioner; name, strength, and quantity of drug, number of refills, if available, and specific directions for the drug's use.
6. The written script must state "For School Use." Example:

   Vial#l Ritalin 5 mg BID
   Vial #2 For School Use
   Ritalin 5 mg. Take one tablet at 11:00 am
   Total Count: Sixty (#60)

7. The Pharmacist will generate an ancillary label to be placed over the original label on the second container (Vial #2) labeled, "For School Use."

   Label: **SCHOOL USE ONLY**
   Take/Use_____at
   AM and at___PM

8. The Pharmacist will dispense estimated twenty (20) day supply for school time dosing in the second container (Vial #2) with the ancillary label. This process will NOT generate a second third party insurance claim.
9. A new Form PHN/SHS 36, "Request for Administration/Storage of Medication," must be completed with any change in medication.
10. Medication order is valid for the current school year. Parent is responsible to obtain the form for the following school year.

If there are questions or more information required, please contact Ruth Ota, Chief, Public Health Nursing Branch at 586-4620 or email at rkota@mail.health.state.hi.us OR Louise Iwaishi, M.D. at 983-8387. Polices and Form PHN/SHS 36 are available at the website address: www.hawaii.gov/doh/publichealthnursing

PHNB: July, 2003

Hawaii-American Academy of Pediatrics-Public Health Nursing Branch-Department of Education Partnership Advisory (H-AAP-PHNB-DOE)

Public Health Nursing Branch, Department of Health, has the responsibility to administer the school health program in the public schools, statewide. The H-AAP-PHNB-DOE Partnership Advisory was formed in January, 1998 to strengthen health room practices in the schools, to strengthen the partnerships with family, medical home, health care systems, Public Health Nursing, Department of Education and other support services in improving the health status of children, and to ensure the continuum of health services from the family to school to medical home.

The Advisory has several workgroups to address the unique medical and health issues that impact on students' learning. Membership in workgroups reflects the expertise in the specific areas. The workgroups are: Respiratory/Pulmonary Disorders; Diabetes; Neurology; Oncology/Hematology; Emergency Medical Services; Information Flow; and Medications.

Members of the H-AAP-PHNB-DOE Partnership Advisory

Melinda Ashton, M.D., Chairperson
Louise Iwaishi, M.D.
Kenn Saruwatari, M.D.
Keith Matsumoto, M.D.
Linda Rosen, M.D.
Kara Yamamoto, M.D.
Jeffrey Okamoto, M.D.
Shigeko Lau, M.D.
Wallace Matthews, M.D.
Sorrell Waxman, M.D.
Galen Chock, M.D.
Kim Hoeldtke, M.D. (military)
Richard Kynion, M.D.(Tripler)
Laura Mulreany, M.D. (Tripler)
Brenda Nishikawa, M.D.
Mae Kyono, M.D.

Ruth Ota, Chief, PHNB, Facilitator
Deanna Helber, DOE
Flory Quarto, PHNB
Todd Inafuku, Pharmacist

PHNB Section Supervisors:
Lily Ochoco, West Honolulu
Charlene Ono, East Honolulu
Jane Yoshimura, Leeward Oahu
Susan Fujii, Central Oahu
Agnes Pigao Cadiz, Windward

Members of the Medication Work Group:

Melinda Ashton, M.D.
Louise Iwaishi, M.D.
Shigeko Lau, M.D.
Wallace Matthews, M.D.
Mae Kyono, M.D.
Brenda Nishikawa, M.D.
Linda Rosen, M.D.
Richard Kynion, M.D.
Marsha Marumoto, M.D.
Noelani Apau, M.D.
Galen Chock, M.D.
Keith Matsumoto, M.D.
Kara Yamamoto, M.D.

Ruth Ota, PHNB, Facilitator
Mel Kumasaka, Pharmacist, Longs
Todd Inafuku, Pharmacist
John Fleming, Food and Drug Branch, DOH
Debora Chan, Pharmacist, Tripler
Deanna Helber, DOE
Grade Matsuo, DOE

PHN Section Supervisors:
Judith Akamine, Hawaii
Lizbeth Olsten, Maui
Joyce Chuang, Kauai
Charlene Ono, representing Oahu

Contact Person for suggestions, comments, questions:

Ruth Ota, RN,M.P.H.
Chief, Public Health Nursing Branch
Department of Health
1250 Punchbowl Street Room 210
Honolulu, HI 96813

Phone:586-4620
FAX: 586-8165
email: rkota@mail.health.state.hi.us

REQUEST FOR ADMINISTRATION / STORAGE OF MEDICATION

AT _____ SCHOOL FOR _____ - _____ YEAR

Please complete form in ink.

CHILD'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM:	BUS. PHONE:
ADDRESS:	ZIP CODE:	HOME PHONE:	Mother: Father:

Please check ( ) child's health insurance plan: QUEST___ MEDICAID ___ CHAMPUS ___ HMSA-Private ___ KAISER-Private ___
OTHER (specify) _____ NONE ___

I. PARENT'S REQUEST AND AUTHORIZATION

I, the undersigned, request and authorize the Public Health Nursing Branch (PHNB) 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: _____

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: _____

DEPARTMENT OF HEALTH AUTHORIZATION

Authorization to SHA/LPN by:

_____ PHN

DATE

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 Public Health Nursing Branch and/or DOE personnel without the completion of this form, PHN/SHS36, Rev. 4/03, and prior approval by PHNB personnel.**

    a. Parent/Legal Guardian must complete Section 1, 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 Health Room at the school or to the Public Health Nurse

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 PHN. 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, which is the same as the written request (PHN/SHS 36) by your child's physician.
    b. Send in refills in a timely manner in properly labeled container/vial before medication runs out.
    c). Provide a picture of your child to the School Health Aide/Special Needs Nurse,
    d). Remind child to report to the Health Room at the designated time.

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.

10. Policies and Guidelines for Administration/Storage of Medications developed by the Hawaii Chapter of Academy of Pediatrics-PHNB-DOE (H-AAP-PHNB-DOE), the PHN/SHS 36 form, and General instructions are available at the website address: www.hawaii.gov/doh/publichealthnursinq. Or contact your Public Health Nurse.

SELF-ADMINISTRATION OF MEDICATION FOR SY: _____

A. Parent's Request and Authorization

I, THE UNDERSIGNED, request and authorize my child _____ to self-administer his/her medication: **inhaler auto-injectable epinephrine (EpiPen)** while at school.
(Circle one or both as appropriate)

This authorization is given based on the following:

- My child is capable of and has been instructed in the proper method of self-administration of this medication.
- I understand that my child shall be permitted to carry at all times his/her medication as long as he/she does not endanger him/herself, or endanger other persons, and will not misuse the medication.
- I understand that if my child misuses or exceeds the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication.

Parent/Guardian Signature: _____ **Date:** _____

I, THE UNDERSIGNED,

- understand that the Department of Education, its employees or agents shall not incur any liability as a result of any injury arising from the self-administration of the medication by my child;
- shall exempt from liability and hold harmless school employees or agents against any claims arising out of the self-administration of medication by my child;
- understand that this authorization shall be effective for this current school year and must be renewed annually.

Parent/Guardian Signature: _____ **Date:** _____

B. Physician's Certification

I, THE UNDERSIGNED, certify that _____ has asthma,
(student's name)

anaphylaxis or another related potentially life-threatening illness _____, and
(specify)

he/she is capable of and has been instructed in the proper method of self-administration of

his/her own asthma and/or auto-injectable epinephrine (EpiPen) medication.
(circle appropriate medication)

Physician's Name: _____ **Physician's Signature:** _____
(type/print)

Address: _____ Telephone: _____ Date _____

Reviewed/Accepted by: _____ Date: _____
Principal or DOE Designee

Received by PHN/SHA: _____ Date _____

REQUEST FOR INDIVIDUALIZED HEALTH CARE PROCEDURES IN SCHOOL - GASTROSTOMY
SCHOOL YEAR _____

Please complete form in ink.

CHILD'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM:
ADDRESS:	ZIP CODE:	HOME PHONE:
SCHOOL:	PHN SECTION (Agency use):	BUS.PHONE: Mother: Father:
Please check () child's health insurance plan: QUEST____MEDICAID____CHAMPUS____HMSA-Private____KAISER-Private____ OTHER (Specify)		NO INSURANCE____

I. PARENT'S REQUEST AND CONSENT FOR SERVICES

I request and authorize the Public Health Nursing personnel to administer individualized health care procedures as prescribed by my child's physician. I understand that a new request with physician's orders is to be processed should there be any change in treatment. I will provide the school with the necessary supplies/equipment to perform this service for my child. This authorization will be in effect for the above stated school year.

PARENT'S NAME:_____ *(type/print)* PARENT'S SIGNATURE:_____ DATE:_____

II. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, public health nurse/special needs nurse, and the school for effective service provision. This authorization will be in effect for the above stated school year.

PARENT'S NAME:_____ *(type/print)* PARENT'S SIGNATURE:_____ DATE:_____

III. PHYSICIAN'S REQUEST

DIAGNOSIS:_____ **WEIGHT:**_____

FORMULA: _____ **HEIGHT:** _____

TUBE TYPE:	❑ **Gastrostomy**		
	a. **Low-profile**	❑ Mickey ❑ Hide-a-Port ❑ Bard button	❑ Other
	b. **Gastrostomy tube**	❑ Ponsky ❑ Flexiflo	❑ Other
	❑ **Jejunostomy**		
ADMINISTRATION:	❑ **Bolus** _____ ml every _____ hours. Administer over _____ minutes. Feeding times: _____ Flush with _____ ml of water. Keep upright or elevate 30° for 30-60 minutes after feeding.		
	❑ **Continuous** _____ ml/hour. Feeding times: _____ Keep upright or elevate 30° during feeding & 30-60 minutes after feeding.		
Other Special Considerations:			

PHYSICIAN'S NAME: _____ *(type/print)* PHYSICIAN'S SIGNATURE: _____

ADDRESS:_____ TELEPHONE:_____ DATE:_____

IV. DEPARTMENT OF HEALTH AUTHORIZATION

Authorization to RN:_____ DATE:_____

Public Health Nurse's Signature

PHN/SH 38GT (Rev. 06/02)

INSTRUCTIONS FOR REQUEST FOR ADMINISTRATION OF INDIVIDUALIZED HEALTH CARE PROCEDURES IN SCHOOL BY SPECIAL NEEDS NURSES

1. This "Request for Administration of Individualized Health Care Procedures (IHCP) in School" is initiated when skilled nursing procedures are deemed necessary to promote the student's health and well being at school. All IHCP will be administered with completion of PHN/SH 38.

2. PARENT must complete SECTIONS I and II.

3. PHYSICIAN must complete SECTION III.

4. When SECTIONS I, II & III have been completed, PARENT is to return this form to the Health Room or Public Health Nurse/Special Needs Nurse.

GENERAL INSTRUCTIONS

1. Only procedures deemed necessary to promote the student's health and well being will be performed during the school day. Determination will be made by evaluating the student's needs and health status.

2. Upon approval of this request, parent:
   a. will be notified.
   b. will be requested to send in all supplies and equipment needed to provide the ordered procedure(s). A list of needed supplies and equipment will be given to parents.
   c. will be requested to provide a clear picture of the student receiving IHCP to the Special Needs Nurse (optional).

3. Should there be any significant change in treatment/procedure order(s) by the physician, a new PHN/SH 38 (order request form) must be processed. This should be sent to school with supplies/equipment needed to perform the procedure(s) in accordance with the new order(s).

4. Any modification in procedure (e.g. amount of tube feeding, time) will require a provider's prescription except on occasions when accommodations are made for off campus activities. The parent should clear these with the physician in advance.

5. This form is good for current school year and must to be renewed annually. Parent is responsible for obtaining form for the following school year.

REQUEST FOR INDIVIDUALIZED PROCEDURES IN SCHOOL - TRACHEOSTOMY
SCHOOL YEAR _____

Please complete form in ink.

CHILD'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM:
ADDRESS:	ZIP CODE:	HOME PHONE:
SCHOOL:	PHN SECTION (Agency use):	BUS.PHONE: Mother: Father:
Please check () child's health insurance plan: QUEST____MEDICAID____CHAMPUS____HMSA-Private____KAISER-Private____ OTHER (Specify)		NO INSURANCE____

I. AUTHORIZATION AND CONSENT FOR SERVICES

I request and authorize the Public Health Nursing personnel to administer individualized health care procedures as prescribed by my child's physician. I understand that a new request with physician's orders is to be processed should there be any change in treatment. I will provide the school with the necessary supplies/equipment to perform this service for my child. This authorization will be in effect for the above stated school year.

PARENT'S NAME:_____ *(type/print)* PARENT'S SIGNATURE:_____ DATE:_____

II. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, public health nurse/special needs nurse, and the school for effective service provision. This authorization will be in effect for the above stated school year.

PARENT'S NAME:_____ *(type/print)* PARENT'S SIGNATURE:_____ DATE:_____

III. PHYSICIAN'S REQUEST

DIAGNOSIS:_____ **WEIGHT:**_____ **HEIGHT:**_____

TRACHEOSTOMY:	❑ **Type:** _____ **Size:** _____ ❑ Artificial nose ❑ If trach gets dislodged,_____	
TREATMENT:	❑ **Suction** and/or **irrigate** with saline every _____ hours ❑ **Ambu Bag prn**: Yes _____ No _____	
	❑ **Oxygen** at _____liters per trach collar, ❑ Humidification	❑ **Continuous** ❑ **Prn**
	❑ **Pulse oximeter**: Check every _____ hours. Maintain oxygen saturation between _____%.	
Other Special Considerations:		

PHYSICIAN'S NAME: _____ *(type/print)* PHYSICIAN'S SIGNATURE: _____

ADDRESS:_____ TELEPHONE:_____ DATE:_____

IV. DEPARTMENT OF HEALTH AUTHORIZATION

Authorization of RN:_____ DATE:_____
Public Health Nurse's Signature

INSTRUCTIONS FOR REQUEST FOR ADMINISTRATION OF INDIVIDUALIZED HEALTH CARE PROCEDURES IN SCHOOL BY SPECIAL NEEDS NURSES

1. This "Request for Administration of Individualized Health Care Procedures (IHCP) in School" is initiated when skilled nursing procedures are deemed necessary to promote the student's health and well being at school. All IHCP will be administered with completion of PHN/SH 38.

2. PARENT must complete SECTIONS I and II.

3. PHYSICIAN must complete SECTION III.

4. When SECTIONS I, II & III have been completed, PARENT is to return this form to the Health Room or Public Health Nurse/Special Needs Nurse.

GENERAL INSTRUCTIONS

1. Only procedures deemed necessary to promote the student's health and well being will be performed during the school day. Determination will be made by evaluating the student's needs and health status.

2. Upon approval of this request, parent:

   a. will be notified.

   b. will be requested to send in all supplies and equipment needed to provide the ordered procedure(s). A list of needed supplies and equipment will be given to parents.

   c. will be requested to provide a clear picture of the student receiving IHCP to the Special Needs Nurse (optional).

3. Should there be any significant change in treatment/procedure order(s) by the physician, a new PHN/SH 38 (order request form) must be processed. This should be sent to school with supplies/equipment needed to perform the procedure(s) in accordance with the new order(s).

4. Any modification in procedure (e.g. amount of tube feeding, time) will require a provider's prescription except on occasions when accommodations are made for off campus activities. The parent should clear these with the physician in advance.

5. This form is good for current school year and must to be renewed annually. Parent is responsible for obtaining form for the following school year.