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

....for Healthier Tomorrows!

Public Health Nursing
...at work in your Community!

Ask us!

Need Help?

Please Call:
Community Based, Family Centered, & Individualized

Public Health Nursing Services

Assisting Individuals and Families

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

- 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

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

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>TARGET POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate mobilization of services during disasters, epidemics, other biologic threats</td>
<td>General population impacted during event</td>
</tr>
<tr>
<td>Control of communicable diseases through contact and source investigations for tuberculosis, Hansen's Disease</td>
<td>Clients suspected/diagnosed with tuberculosis, Hansen's Disease, or other communicable diseases</td>
</tr>
<tr>
<td>Immunization services through immunization clinics and follow-up; facilitate access to medical home and health insurance program</td>
<td>Children with no health insurance or having difficulty accessing the health care system; children behind with immunizations</td>
</tr>
<tr>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>School Health Services: Specialized health care procedures( i.e. suctioning, gastrostomy feeding, etc.) administered by licensed practical nurses</td>
<td>Eligible students under Individual Disabilities Education Act (IDEA), Part B</td>
</tr>
<tr>
<td>Care Coordination Services to infants and toddlers for Early Intervention Services</td>
<td>Infants and toddlers (birth to age 3) with complex medical conditions or considered medically fragile, under IDEA, Part C.</td>
</tr>
<tr>
<td>Care Coordination services to special needs population with medical/health conditions to facilitate access to services and support caregivers</td>
<td>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.</td>
</tr>
<tr>
<td>Other groups to facilitate access to services</td>
<td>Homeless; Immigrants</td>
</tr>
<tr>
<td>Working in collaboration with community</td>
<td>Specific to community needs</td>
</tr>
</tbody>
</table>

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

* Molokai and Lanai under Maui PHN Section
REQUEST FOR NURSING SERVICES

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: (Man) Last First BD: / / Phone: ____________________________________________________________________________

other

MOTHER: (Woman) Last First BD: / / Phone: ____________________________________________________________________________

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**

<table>
<thead>
<tr>
<th>Name</th>
<th>(Last)</th>
<th>(First)</th>
<th>(Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>Month - Day - Year</td>
<td></td>
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</tr>
<tr>
<td>Parent's Name</td>
<td>(Mother/Guardian) - (FATHER/GUARDIAN)</td>
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<tr>
<td>Student Address Label</td>
<td></td>
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</tbody>
</table>

**MEDICAL STATUS**

- **Allergy (type)**
  - Cancer/Lymphoma
  - Asthma
  - Vision Problems

- **Medical Conditions**
  - Hearing Problems
  - Heart Disease
  - Hemophilia
  - Diabetes

**PHYSICIAN'S EXAMINATION CODE:**

- **N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE**

<table>
<thead>
<tr>
<th>Date</th>
<th>Grade</th>
<th>Height</th>
<th>Weight</th>
<th>Vision Problems</th>
<th>Hearing</th>
<th>Ears</th>
<th>Nose</th>
<th>Throat</th>
<th>Heart</th>
<th>Lungs</th>
<th>Stomach</th>
<th>Nervous System</th>
<th>Skin</th>
<th>Scoliosis</th>
<th>Extremities</th>
<th>Nutrition</th>
<th>Significant Findings and Recommendations</th>
<th>Varicella</th>
<th>Immunity to Secondary to Disease (DATE)</th>
<th>Pneumonia</th>
<th>Immunization Record (Check if Yes)</th>
<th>Immunization Record (Check if Yes)</th>
<th>Provider's Signature</th>
<th>Provider's Stamp or Printed Name</th>
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</table>

**TUBERCULOSIS EXAMINATION**

- **MANToux Test (intradermal)**

<table>
<thead>
<tr>
<th>Date Given</th>
<th>Date Read</th>
<th>Results (mm)</th>
<th>Physician, APRN, PA, or Clinic (Signature or Stamp if Different from Above)</th>
</tr>
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</tbody>
</table>

**CHEST X-RAY**

<table>
<thead>
<tr>
<th>Date</th>
<th>Results</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
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</table>

**DENTAL EXAMINATION**

- **Dental Check-Up**

| /    | / |

**IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DATE/YEAR)**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Type</th>
<th>Date Given</th>
<th>Type</th>
<th>Date Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td></td>
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<tr>
<td>DTP</td>
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<tr>
<td>dT</td>
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<tr>
<td>Haemophilus Influenzae type B</td>
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</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
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</tr>
<tr>
<td>Varicella</td>
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<tr>
<td>MMR</td>
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</tr>
</tbody>
</table>

**OTHER**

- Measles
- Mumps
- Varicella
- 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.)

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature &amp; Title</th>
<th>Date</th>
<th>Signature &amp; Title</th>
</tr>
</thead>
</table>
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#1 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.
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. Policies 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 Fuji, Central Oahu
  Agnes Piga 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
e-mail: 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) ____________________

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) 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:

<table>
<thead>
<tr>
<th>MEDICATION Name/Dosage</th>
<th>EXACT TIME OR RANGE OF TIME TO BE GIVEN</th>
<th>SPECIAL INSTRUCTIONS</th>
<th>DURATION OF TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

PRN MEDICATION:

<table>
<thead>
<tr>
<th>MEDICATION Name/Dosage</th>
<th>SPECIFIC INDICATIONS FOR USE</th>
<th>REASON(S) WHY PRN MEDICATION IS NEEDED IN SCHOOL (REQUIRED RESPONSE)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Physician’s Signature: ____________________

DATE: ____________________

Physician’s Name: ____________________ (type/print)

ADDRESS: ____________________

Telephone: ____________________ FAX: ____________________

DEPARTMENT OF HEALTH AUTHORIZATION

Authorization to SHA/LPN by: ____________________

DATE: ____________________ PHN

DEPARTMENT OF HEALTH AUTHORIZATION

Authorization to SHA/LPN by: ____________________

DATE: ____________________ PHN

SEE ON BACK (Page 1 of 2)
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.
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 ______________________ (student’s name) has asthma, anaphylaxis or another related potentially life-threatening illness ______________________, and 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)  Telephone: ______________ Date ______________

Address: ___________________________ Reviewed/Accepted by: ___________________________ Date: ______________

Received by PHN/SHA: ___________________________ Date: ______________

DOE: July, 2004  Inhaler and EpiPen Consent Form
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): 
Mother: 
Father: 
BUS PHONE: 
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: 
SIGNATURE: 
DATE: 
(type/print)

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: 
SIGNATURE: 
DATE: 
(type/print)

III. PHYSICIAN’S REQUEST

DIAGNOSIS: 
WEIGHT: 
FORMULA: 
HEIGHT:

<table>
<thead>
<tr>
<th>TUBE TYPE:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Gastrostomy</td>
<td>☐ Mickey</td>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Low-profile</td>
<td>☐ Hide-a-Port</td>
<td>☐ Bard button</td>
</tr>
<tr>
<td>☐ Jejunostomy</td>
<td>☐ Ponsky</td>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Gastrostomy tube</td>
<td>☐ Flexilfo</td>
<td></td>
</tr>
</tbody>
</table>

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: 
SIGNATURE: 
ADDRESS: 
TELEPHONE: 
DATE: 
(type/print)

IV. DEPARTMENT OF HEALTH AUTHORIZATION

Authorization to RN: 
Public Health Nurse’s Signature 
DATE: 
PHN/SH 38GT (Rev. 06/02)
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 ____________

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: ___________________________ PARENT’S SIGNATURE: ___________________________ DATE: ___________________________
(type/print)

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: ___________________________ PARENT’S SIGNATURE: ___________________________ DATE: ___________________________
(type/print)

III. PHYSICIAN’S REQUEST

DIAGNOSIS: ___________________________ WEIGHT: ___________________________
HEIGHT: ___________________________

RACHEOSTOMY:

☐ 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, ☐ Continuous ☐ Prn
☐ Humidification
☐ Pulse oximeter: Check every _________ hours.
Maintain oxygen saturation between _________ %.

Other Special Considerations:

PHYSICIAN’S NAME: ___________________________ PHSICIAN’S SIGNATURE: ___________________________
(type/print)
ADDRESS: __________________________________ TELEPHONE: ___________________________ DATE: ___________________________

IV. DEPARTMENT OF HEALTH AUTHORIZATION

Authorization of RN: ___________________________ DATE: ___________________________

HN/SH38TR (Rev. 06/02) 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.

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