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...VERNOR OF HAWAII

BRUCE S. ANDERSON, Ph.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
Communicable Disease and Public Health Nursing Division
Public Health Nursing Branch

In reply, please refer to:
File:

Dear Parent/Legal Guardian,

The Department of Education works with the Department of Health to ensure that your child's medical condition is adequately addressed in the school setting. The Public Health Nurse (PHN) will work with you, your child's health care provider(s), and the school staff to accomplish this.

If your child needs emergency or scheduled daily medication(s) to be given at school, and/or an Emergency Action Plan (EAP), please **complete, sign and date** the following forms:

_____ If your child needs a daily or rescue medication to be given at school, please complete the **SH36 "Request to Store and Administer Emergency Rescue Medications or Daily, Routine, Scheduled Medications"** form. Please review and follow the instructions:

- Please read all 3 pages and **return only pages 1 and 2.**
- Check **ALL** boxes on page 1 and sign.
- Please have your child's health care provider complete and sign page 2.

_____ The **"Authorization for Use or Disclosure of Protected Health Information" (School)** form allows the Public Health Nurse to share your child's health information with the Department of Education.

_____ The **"Authorization for Use or Disclosure of Protected Health Information" (Medical Provider)** form allows the Public Health Nurse to discuss your child's health condition and/or medication(s) with your child's health care provider.

_____ The **"Notice of Privacy Practices"** form informs you that your child's health information is kept confidential by Public Health Nursing. You should have received two copies. Please sign one copy while the second copy is for your records.

Once the above items (√) have been completed and received by the School Health Assistant or the Public Health Nurse, the Public Health Nurse will contact you for a consultation.

If you have any questions, please contact Jesslyn Lau, Public Health Nurse Consultant, at (808) 733-8305. Thank you for your cooperation.

Sincerely,

Jesslyn Lau, RN

Jesslyn Lau, RN, Public Health Nurse
East Honolulu Public Health Nursing Section
3627 Kilauea Avenue, #311
Honolulu, HI 96816
Phone: (808) 733-8305
Fax: (808) 733-9375

STATE OF HAWAII

DEPARTMENT OF EDUCATION

REQUEST TO STORE AND ADMINISTER EMERGENCY RESCUE MEDICATIONS AND DAILY, ROUTINE, SCHEDULED MEDICATIONS, AS APPLICABLE

AT NOELANI SCHOOL SCHOOL FOR _____ SCHOOL YEAR

Please complete this form in ink.

STUDENT'S NAME (Last, First):		BIRTHDATE:	GRADE/HOMEROOM #
HOME ADDRESS:		HOME PHONE:	
Mother's Name:	Home Ph #:	Cell #:	Work #:
Father's Name:	Home Ph #:	Cell #:	Work #:
Legal Guardian's Name	Home Ph #:	Cell #:	Work #:
Please check student's health insurance plan: QUEST ☐ MEDICAID ☐ TRICARE ☐ HMSA-Private ☐ KAISER-Private ☐			
OTHER (specify):	NONE ☐		

I. PARENT'S / LEGAL GUARDIAN'S REQUEST, AUTHORIZATION, and WAIVER OF LIABILITY

Request and Authorization:

I, the undersigned, request and authorize the following individuals to administer medication to my child as prescribed by my child's physician or other practitioner with prescribing authority in a medication order: personnel of the Department of Education (DOE), personnel of the Department of Health (DOH), and nurses assigned by the DOE pursuant to a written agreement.

I request and authorize the release of health information among the DOE, the DOH Public Health Nurse (PHN), the prescribing physician or other practitioner with prescribing authority, and the dispensing pharmacist pertinent to my child's condition. I understand that I will be informed by the PHN, the prescribing physician or other practitioner with prescribing authority if there are any changes to my child's medication order.

- ☐ **I have read the instructions on page 3 of this request form, "Notice to Parents/Legal Guardians and Physicians."**
- ☐ **I will provide a recent photograph of my child.**
- ☐ **I agree I am responsible to provide appropriately labeled medications in accordance with the instructions on page 3 of this request form.**

PARENT'S/LEGAL GUARDIAN'S SIGNATURE: _____

PARENT'S/LEGAL GUARDIAN'S (Type/Print): _____

DATE: _____

Waiver of Liability:

NOTICE: The DOE, the DOH, and their employees and/or agents shall not incur any liability as a result of any injury arising from the administration of the emergency rescue medications or daily, routine, scheduled medications specified on this form.

My signature below indicates that:

- I understand and I agree that the medication may be administered by a specifically trained non-health care professional; and
- I agree that the DOE and the DOH and their employees or agents, including nurses assigned by the DOE pursuant to a written agreement, shall not incur any liability as a result of any injury arising from the administration of the emergency rescue medications or daily, routine, scheduled medications specified on this form.

PARENT'S/LEGAL GUARDIAN'S SIGNATURE: _____

PARENT'S/LEGAL GUARDIAN'S (Type/Print): _____

DATE: _____

Student's Name: _____ Birthdate: _____

II. PHYSICIAN'S or OTHER HEALTH PROFESSIONAL'S REQUEST

DIAGNOSIS: _____

WEIGHT: _____ ALLERGIES: _____

EMERGENCY RESCUE MEDICATIONS AND DAILY, ROUTINE, SCHEDULED MEDICATIONS:

EMERGENCY RESCUE MEDICATION (Name/Dosage/Route)	TIME TO BE GIVEN	DESCRIPTION OF	OTHER ADMINISTRATION INFORMATION Rescue Medications
EMERGENCY RESCUE MEDICATION -- Epinephrine: □ **Epinephrine auto-injector,** Premeasured dose of **0.15 mg**, IM (33-66 lbs) □ **Epinephrine auto injector,** Premeasured dose of **0.3 mg**, IM (>66 lbs)	**First administration**: Immediately upon onset of life-threatening symptoms. **Second administration:** Repeat dose in ___ minutes of first administration.	**Life threatening SYMPTOMS:**	**Actions for Epinephrine:** The school shall call 911 immediately after first administration. The school shall notify the parent/legal guardian after calling 911.
EMERGENCY RESCUE MEDICATION -- Inhaler: □ **Inhaler (Name):** _____ **Dosage**_____**/#puffs:**_____	**Upon onset of Asthma Symptoms.**	**Asthma SYMPTOMS:**	**Action for Inhaler:** If assigned nurse is available, nurse can assist, assess student for decision on disposition. If no nurse is available, call parent to pick up student after administration of medication per SHA Manual procedure. Call 911 if indicated in student's Emergency Action Plan.

DAILY, ROUTINE, SCHEDULED MEDICATION (Medication/Dose/Frequency/Route)	TIME(S) TO BE GIVEN:	Reason(s) medication(s) need(s) to be given during the school day:

The above indicated medication(s) is/are necessary for the health of the student and for the student's attendance at school and school related functions: □ **Yes** □ **No**

Physician's (or other practitioner with prescriptive authority) Signature: _____ DATE: _____

Physician's (or other practitioner with prescriptive authority) Name (type/print): _____

Telephone: _____ FAX: _____

Address: _____ City: _____ Zip: _____

Note: SH36 review and consultation has been completed by an agent of the DOH. Administration of medication to the above named student as requested by the parent/legal guardian and prescribed by the physician

□ **is approved by the DOH for administration in the school setting.**

□ **is not approved by the DOH for administration in the school setting.**

DOH PHN's Initial: _____ **Date:** _____

Hawaii State Department of Health

Authorization for Use or Disclosure of Protected Health Information (PHI)

Individual/Organization Disclosing Protected Health Information	
Name: Hawaii State Department of Health, East Honolulu PHN Section	Address: Diamond Head Health Center, 3627 Kilauea Avenue, #311, Honolulu, HI 96816
Individual/Organization That Will Receive the Individual's Protected Health Information	
Name: Hawaii State Department of Education, Noelani Elementary	Address: 2655 Woodlawn Drive, Honolulu, HI 96822
Individual Whose Protected Health Information Is Being Requested	
First Name:	Last Name:
Address:	Birthdate (if known):

I Authorize That the Following Protected Health Information Be Used or Disclosed (be specific and identify limits, as appropriate. Initial in the space provided if this Authorization includes the use or disclosure of specially protected health information):

Exchange of information regarding student's condition:
Including medication, treatment, and any precautions that need to be addressed in the school setting

_____ Mental Health _____ Substance Abuse Treatment _____ HIV/AIDS

The Protected Health Information Is Being Used or Disclosed for the Following Purpose(s) ("At the request of the individual" is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose):

( ) Development of an Emergency Action Plan ( ) Administration of medication ( ) Provision of Skilled Nursing services at school

Authorization Duration (This Authorization will be enforced and in effect until the date **OR** event specified below. At that time, this Authorization to use or disclose this Protected Health Information expires):

Authorization Expiration Date **OR** Event:

Upon exit from DOE/Noelani Elementary School

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the use or disclosure of the Protected Health Information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA, 34 CFR Part 99) and alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or redisclosed without my authorization.

The entity or person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating Protected Health Information for disclosure to a third party.

The use or disclosure requested under this Authorization will result in direct or indirect remuneration to the Department from a third party. (Check this box ONLY if the disclosing party will receive compensation or other benefit when using or disclosing this Protected Health Information). ☐

Individual or Personal Representative Signature:	Date:
Print Name of Individual or Personal Representative:	Description of Personal Representative's Authority:

Hawaii State Department of Health

Authorization for Use or Disclosure of Protected Health Information (PHI)

Individual/Organization Disclosing Protected Health Information	
Name: Medical provider's name:	Address: Medical provider's address:
Individual/Organization That Will Receive the Individual's Protected Health Information	
Name: Hawaii State Department of Health, East Honolulu Public Health Nursing Section	Address: 3627 Kilauea Ave, Room 311, Honolulu, HI 96816
Individual Whose Protected Health Information Is Being Requested	
First Name:	Last Name:
Address:	Birthdate (if known):

I Authorize That the Following Protected Health Information Be Used or Disclosed (be specific and identify limits, as appropriate. Initial in the space provided if this Authorization includes the use or disclosure of specially protected health information):

Exchange of information regarding student's condition:
Including medication, treatment, and any precautions that need to be addressed in the school setting

_____ Mental Health _____ Substance Abuse Treatment _____ HIV/AIDS

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The entity or person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating Protected Health Information for disclosure to a third party.

The use or disclosure requested under this Authorization will result in direct or indirect remuneration to the Department from a third party. (Check this box ONLY if the disclosing party will receive compensation or other benefit when using or disclosing this Protected Health Information). ☐

Individual or Personal Representative Signature:	Date:
Print Name of Individual or Personal Representative:	Description of Personal Representative's Authority:

NOTICE TO PARENTS/LEGAL GUARDIANS AND PHYSICIANS
(Please keep this page for your future reference.)

Please note: School health aides are unlicensed non-health professionals who are specifically trained in medication administration. They are not able to perform clinical assessments necessary to determine the need for medication or response to medication, but they are provided with protocols to follow in situations where medication is needed.

1. Medications that are provided by the parent/legal guardians pursuant to this form, shall be stored in the school health room. No other medications will be stored in school.
2. Medications should be given at home as much as possible unless the physician or other practitioner with prescriptive authority provides reasons on this form why medications must be given during the school day or at a beyond-the-school day event/program. In that event, emergency rescue medications and daily, routine, scheduled medications shall be administered as prescribed and requested by this form.
3. Antibiotics, analgesics, and over-the-counter medications will not be stored or administered at school.
4. No "as needed" pro re nata (PRN) medications will be stored or administered during the school day because school health aides administering medication are not able to perform clinical assessments necessary to determine the need for medication.
5. Epi-Pen, Glucagon and inhalers, defined as emergency rescue medications, may be administered on an emergency basis if they have been prescribed by a physician or other practitioner with prescriptive authority, and the parent/legal guardian has requested their administration in accordance with this form, or with Hawaii Revised Statutes (HRS) §302A-853.
   Epi-Pen or Glucagon: When administered, the school will call 911 and notify the parent/legal guardian. The school will defer to Emergency Medical Service (EMS) personnel with respect to whether transport to a medical facility is needed. If EMS personnel determine that transport to a medical facility is not needed, the parent/legal guardian will be informed to pick up the student.
   Emergency inhalers: When administered by an unlicensed non-health professional, the school will notify the parent/legal guardian to pick up the student. When administered by the assigned nurse, the nurse may assess the student and determine whether to allow the student to remain in school or be sent home.
6. No medications will be administered by the authorized DOE or DOH personnel without the completion of this SH36, Revised 2016, which includes the following requirements:
   a. Parent/legal guardian must complete Section I, PARENT'S/LEGAL GUARDIAN'S REQUEST, AUTHORIZATION, and WAIVER of LIABILITY;
   b. Physician or other practitioner with prescriptive authority must complete Section II, Physician's or Other Health Professional's Request;
   c. DOH must approve the form; and
   d. The completed form must be submitted by the PHN to the School Health Aide at the school, and maintained on file in the school health room.
7. In order for medications to be stored and administered in school, the medications must:
   a. Be dispensed by a pharmacist in accordance with HRS §328-16 (a)(10);
   b. Be in a container/vial labeled **"FOR SCHOOL USE;"**
   c. Include the name of the student, name of the medication, dosage, strength, time of administration, and name of prescribing physician or other practitioner with prescribing authority. The instructions on the container must state, **"FOR SCHOOL USE;"** and
   d. Be designated on a completed Form SH36.
8. Parent/legal guardian is responsible for providing an appropriately labeled supply of medications and a recent photo of their child to the health room at school. This should be coordinated with the school health aide, the child's teacher(s), and the school principal. Medications that are discontinued or unused must be picked up by the parent/legal guardian.
9. Should there be any new medication order(s) by the physician or other practitioner with prescribing authority, a new "Request to Store and Administer Emergency Rescue Medications and Daily, Routine, Scheduled Medications, As Applicable" (SH36, Rev. 2016) must be completed and submitted as specified in this form. The form may be sent to school with the new container/vial of medication to reflect the new order(s) using the process specified on this form. Prescription refills based on the prescription on file do not require a new form.
10. If your child is off campus during the regular school day to participate in a DOE sponsored activity, prior arrangements must be made between the parent/legal guardian and the school in order for your child to be able to receive scheduled medications. Otherwise, your child will **NOT** be able to receive the scheduled medication for the day.
11. **This form is applicable only for the current school year and must be renewed yearly. Parent/legal guardian are responsible for submitting requests for the following school year**

PLEASE SIGN THE BACK AND RETURN TO HEALTH ROOM

Notice of Privacy Practices

Hawaii Department of Health
Public Health Nursing Branch (PHNB)

Effective January 1, 2012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Information

Each time a Public Health Nurse or staff from PHNB visits you, a record of the visit is made in your health record.

- Health, family, social, educational, and other information provided by you is maintained in your health record.
- Your record may also contain your screening and test results, immunization record, diagnoses, treatment, and a plan for your ongoing care. Medical and hospital reports, and other information obtained with your writteh permission may be part of your record.
- Your health record serves as the basis for:
  - Planning your care and treatment;
  - Communicating with other health professionals involved in your care;
  - Documenting the nursing services you receive; and
  - Assessing and continually working to improve your health care

Your Health Information Privacy Rights

Although your health record is the physical property of PHNB, the information belongs to you. You have the right to:

- See and get a copy your health information;
- Receive this notice that tells you how your health information may be used and shared;
- File a complaint with PHNB without fear of retaliation if you believe that your privacy rights are being denied or your health information isn't being protected;
- Ask to have corrections added to your health information;
- Ask that certain health information not be shared for particular reasons; however, PHNB may not be required to agree with your request; and
- Ask PHNB to communicate with you about your health information in a different way or at a different location.

PHNB Responsibilities

PHNB will:

- Ensure the privacy of your health information;
- Provide you with a copy of this notice which describes our privacy practices regarding information we collect and maintain about you; and
- Abide by the terms of this Notice of Privacy Practices currently in effect.

Should our privacy practices change, we reserve the right to make the new provisions effective for all health information we maintain. Any significant change will be reflected in a revised Notice of Privacy Practices which will be available on or after the effective date of the change.

Even if you have agreed to receive this notice electronically, you may receive a paper copy on request.

How Is PHNB Permitted to Use or Share your Information?

With your Authorization: You may give written permission or authorize PHNB to share your information with any person or entity you choose, such as your insurance company, certain members of your family, your attorney, or your employer.

To do this, you must complete, sign, and date an **Authorization Form.** You may cancel your authorization in writing at any time; however, your cancellation will not apply to the actions already taken by PHNB when your authorization was in effect.

Without your Authorization: Current privacy laws allow PHNB to use and share your health information without first obtaining your written permission for the following purposes:

For your treatment. For example, PHNB may use your health information to remind you about a health appointment. Most importantly, your information may be used and shared with the members of your health care Treatment Team to determine the best course of care for you.

For administrative health care operations. For example, members of the PHNB Quality Improvement Team may use your health information to assess the care and outcomes in your situation and others like it. This information may then be used to continually improve the quality and effectiveness of the services we provide.

For public health activities. PHNB may share your health information with public health authorities charged with preventing or controlling disease, injury, or disability.

When required by law. For example, the law requires PHNB to report gunshot wounds to the police.

To report suspected abuse or neglect. The law requires PHNB to report suspected abuse or neglect to Child or Adult Protective Services or the police. The report may contain health information.

For judicial purposes. For example, PHNB may share specific health information in response to a court order, administrative tribunal request, subpoena, or discovery request.

To law enforcement officials. PHNB may share health information relating to crime victims, suspicious deaths, crime suspects, about crimes that occur on its premises, or as required by law.

To avert a serious threat to health or safety. For example, PHNB may in good faith provide information to the police when faced with a person who is threatening to use a dangerous weapon to harm himself and others.

For care and notification purposes if you agree and do not object: For example, PHNB may share your treatment plan with your daughter who takes care of you, or notify the Red Cross of your location during a disaster.

About deceased persons. PHNB may share he alth information with the medical examiner seeking to identify a person and the cause of death; and with funeral directors to carry out their official duties.

For organ, eye, or tissue donation. PHNB may share health information for transplantation or tissue donation purposes.

For research purposes. PHNB may share health information with researchers after an Institutional Review Board has ensured the research proposal protects the privacy of your health information.

For health oversight activities. For example, PHNB is required to provide health information requested by the U.S. Dept. of Health and Human Services during an investigation.

For specialized government functions. For example, PHNB may share health information with a correctional institution to ensure the health and safety of inmates or others in the facility.

To other government agencies or organizations. PHNB may share your health information with another government agency to coordinate public benefits you may receive.

For all other purposes: PHNB may share your health information only if you provide us with your written authorization, or as required or permitted by law.

Note about other Federal and State laws:

1. **Specially protected health information.** The rules for sharing mental health, alcohol/substance abuse, HIV/AIDS, and developmental disabilities health information may differ due to stricter Federal or State laws.

2. **Educational records.** If your child's records are considered educational records, PHNB will share this type of information according to the Family Educational Rights Privacy Act (FERPA). Your child's FERPA Notice is provided to you by the Department of Education.

Questions or Complaints?

If you have **questions or concerns,** or if you wish to **file a complaint** because you believe that your privacy rights are being denied or your health information isn't being protected, please contact PHNB at:

Public Health Nursing Branch Chief

1700 Lanakila Avenue # 201

Honolulu, HI 96817

Phone: (808) 832-5765 Fax: (808) 832-5742

You may file a privacy complaint without fear of threat, coercion, discrimination or other retaliatory action from PHNB.

Dislaimer: PHNB is not a HIPAA-covered entity but has elected to follow HIPAA guidelines as best practices.

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices:

X_____

Signature of Individual/ Parent/ Legal Representative

If signed by the Legal Representative, your relationship to the individual: _____

Today's date: X_____

PHNB use only

☐ *Patient was provided a copy of the Notice of Privacy Practices, but refused to sign the acknowledgment.*

Staff signature *Date*

Distribution: Original on file in health record. Copy to patient.