# Waolani Judd Nazarene School

*Where faith and learning reflect the character of Christ*

408 N. Judd Street, Honolulu, HI 96817 ·808-531-5252 · Fax: 1-866-586-WJNS (9567) · office@wjns.org · www.wjns.org

**REQUEST TO ADMINISTER PRESCRIBED MEDICATION AND/OR EMERGENCY RESCUE MEDICATION(S)**

**For _____-_____ SCHOOL YEAR**

Please complete form below:

| Student Name: | Birthdate: | Grade/Room: | Contact Info:<br>Mother's Name:<br>Mother's Phone:<br>Father's Name:<br>Father's Phone: |
|---|---|---|---|
| Address: | | ZIP Code | |
| Student's Health Insurance Plan:<br>☐ HMSA ☐ UHA ☐Kaiser ☐ Quest ☐Medicaid ☐ TRI-Care ☐ Other: _____ ☐ None | | | |

**PARENT'S/LEGAL GUARDIAN'S REQUEST AND AUTHORIZATION**

I, the undersigned, request and authorize the personnel of Waolani Judd Nazarene School to administer medication as prescribed by my child's physician. I request and authorize the release of health information between the school, the prescribing physician, and the pharmacist pertinent to my child's condition. I understand that a new request is needed should there be any change to the medication order.

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

**PHYSICIAN'S REQUEST**

Diagnosis: _____ Weight: _____

Medication/Allergies: _____

**EMERGENCY RESCUE MEDICATION OR DAILY, ROUTINE, SCHEDULE MEDICATION:**

| Medication Name/Dosage | Time | Symptoms | Reason Medication Needs to be given during school day |
|---|---|---|---|
| EMERGENCY RESCUE MEDICATION<br>☐ Epi-Pen: _____ | Upon onset of Life-Threatening Symptoms | | RESCUE MEDICATIONS (will be administered once and 911 and/or parent will be immediately notified) |
| EMERGENCY RESCUE MEDICATION<br>☐ Inhaler: _____ | | | |
| DAILY ROUTINE SCHEDULED MEDICATION | | | |

Physician's Signature: _____ Date:_____

Physician's Name: _____

Phone:_____ FAX: _____

Address:_____

Physician Emergency Contact Number: _____