KAMEHAMEHA SCHOOLS®

MEDICAL FORMS: Kamehameha Schools Summer Programs

Hoʻomākaʻikaʻi

The program that your child is applying to is a rigorous program requiring healthy learners. If medical conditions change at any time, please contact your Health Room to update your child's medical record.

INSTRUCTIONS:

1. For all students: A **Physical Evaluation Form** (page 3) is required.
   - ***a.*** Fill out your child's **Health History** form (page 2) and give it to your child's healthcare provider with the Physical Evaluation form. Please do not upload this Health History when submitting your child's physical.
   - ***b.*** The **date of the physical examination** must be **on or after JANUARY 1, 2024.** If your child already had a physical examination after this date, your child's doctor can complete the Physical Evaluation form based on that physical examination.
   - ***c.*** The Physical Evaluation form must be signed by a physician, nurse practitioner, or physician assistant.
2. For all students: Ask your child's healthcare provider for a print out of your child's **current immunization record** with documentation of having been fully immunized based on age with the vaccinations required for each grade outlined below.
3. If your child requires **necessary, prescription medications** to be administered while attending the program, please complete the **Request for Administration of Medication (RAM)** form (page 5). Instructions for completing the RAM form can be found on page 4.
   - ***a.*** *Please note: Our Health Rooms have acetaminophen, ibuprofen (liquid, chewable, and tablet), loratadine (chewable and tablet), and chewable TUMS in stock. These medications can be given to your child during the program if needed, with your permission.*
4. If your child has a **seizure condition**, the **Medical Clearance for Students with Seizures and Waiver-Indemnification Form** must be completed by parent/guardian(s) and your child's physician. This form can be downloaded from https://www.ksbe.edu/malama-ola/forms. A RAM form must be completed for any rescue medications that your child is prescribed.
5. All documents should be uploaded to the Mo'omō'ali Olakino (EHR) Parent Portal. Details on how to submit required forms will be provided upon acceptance into the program. Submission of medical forms alone does NOT confirm enrollment to the program.

	Entering Grade		
Required Vaccination	**K-6**	**7-10**	**11-12**
Diphtheria-Tetanus-Pertussis (DTP or DTaP)	✓	✓	✓
Hepatitis A	✓	✓	✓
Hepatitis B	✓	✓	✓
Measles-Mumps-Rubella (MMR)	✓	✓	✓
Polio (IPV or OPV)	✓	✓	✓
Varicella (chickenpox)	✓	✓	✓
Tetanus, diphtheria, acellular pertussis (Tdap)		✓	✓
Human papilloma virus (HPV)*		✓	✓
Meningococcal conjugate vaccine (MCV)		✓	✓
Meningococcal conjugate vaccine (MCV)**			✓

*Two does are required if <age 15 years at initial vaccination; three does if age 15 years or older.

**One dose of MCV administered after age 16 years is required.

Email **hmkkmalamaola@ksbe.edu** with any questions related to medical requirements.
Please include your keiki's full legal name, island of residence, and your name in your email. Mahalo!

Instructions: Complete this page and give it to your healthcare provider to review. Do not return this page to KS.

Student Name_____ Date of Birth_____

General Questions	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
Heart Health Questions About You	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐High Blood Pressure ☐ A heart murmur ☐High cholesterol ☐ A heart infection ☐Kawasaki disease ☐ Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
Heart Health Questions About Your Family	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
Bone and Joint Questions	**Yes**	**No**
17. Have you ever had any stress fracture, broken or fractured bones, or dislocated joints?		
18. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
19. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)?		
20. Do you regularly use a brace, orthotics, or other assistive device?		
21. Have you ever had or do you currently have a bone, muscle, or joint injury that bothers you?		
22. Do any of your joints become painful, swollen, feel warm, or look red?		
23. Do you have any history of juvenile arthritis or connective tissue disease?		

Medical Questions	Yes	No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. In the past year, have you used an inhaler or taken asthma medicine?		
26. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
27. Do you have groin pain or a painful bulge or hernia in the groin area?		
28. Have you had infectious mononucleosis (mono) within the last month?		
29. Have you had a herpes or MRSA skin infection?		
30. Have you ever had a head injury or concussion? If so, date of last occurrence:		
31. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
32. Do you have a history of seizure disorder?		
33. Do you have headaches with exercise?		
34. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
35. Have you ever been unable to move your arms or legs after being hit or falling?		
36. Have you ever become ill while exercising in the heat?		
37. Do you get frequent muscle cramps when exercising?		
38. Do you or someone in your family have sickle cell trait or disease?		
39. Have you had any problems with your eyes or vision?		
40. Have you had any eye injuries?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42. Do you worry about your weight?		
43. Are you trying to or has anyone recommended that you gain or lose weight?		
44. Are you on a special diet or do you avoid certain types of foods?		
45. Have you ever had an eating disorder?		
46. Do you have any concerns that you would like to discuss with a doctor?		
47. Do you take any nutritional or dietary supplements?		
48. Have you ever tested positive for COVID-19?		
Females Only	**Yes**	**No**
49. Have you ever had a menstrual period?		
50. How many periods have you had in the last 12 months?		

For "Yes" responses, provide details below (use additional sheets if needed):

_____

Signature of Parent/Guardian Date

Hoʻomākaʻikaʻi Program

KAMEHAMEHA SCHOOLS PHYSICAL EVALUATION FORM (K-12)

Instructions: Complete the top line and have your healthcare provider complete the rest.
Please ensure all fields are completed before returning this form.

Student Name: _____ **DOB**: _____ **Grade Entering**: _____ **ID #**: _____

PROVIDER TO COMPLETE (Blank fields will be considered as None or Normal)		
Medical and Mental Health Conditions:	h/o COVID-19: ☐ Yes ☐ No If yes, date of test:_____ Severity of illness:	**Allergies/Reactions**:
Current Medications & Dosage:	Epi-Pen: ☐ Yes ☐ No Albuterol Inhaler: ☐ Yes ☐ No	**Additional Comments:**

Please send most current immunization record with PE form.

Height:	Weight:	BMI:	Vision: R 20 / L 20 / Corrected ☐ Yes ☐ No
BP:	Pulse:	**Normal**	**Abnormal Finding**
Appearance • Marfan stigmata			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic			
Musculoskeletal • Neck/back • UE/shoulder/elbow/wrist/hand • LE/hip/knee/ankle/foot • Functional/duck walk/single leg hop			
Mental Health • Depression • Tobacco/ Vaping Use			

MEDICAL CLEARANCE

All sections must be addressed in order for the student to be able to participate. Any section left blank will be considered "not cleared" and student will not be able to participate in the activity.

	Medically Cleared (check all that apply)		Restrictions or other Comments
	Yes	No	
School			
Physical Education			
Sports			

I have reviewed the Health History and completed the physical examination documented on this form for the above-named student. Based on my clinical assessment, the student is cleared to attend school and participate in physical education and sports as indicated above. I attest that I am a licensed physician (MD, DO), Nurse Practitioner (NP or APRN), or Physician Assistant (PA).

Name of Provider _____ **Examination Date** _____

Address _____ Phone _____

Signature of Provider _____ Date of form completion _____

KAMEHAMEHA SCHOOLS

MĀLAMA OLA ● Health Services Department

INSTRUCTIONS FOR REQUEST FOR ADMINISTRATION OF MEDICATION

1. The *Request for Administration of Medication* form is required and initiated when any medication (prescription and/or over-the-counter) must be administered in school and it is not possible to schedule all dosages at home. ***A separate Request for Administration of Medication form must be completed for each individual medication.*** Medication shall be stored in the Medical/Health Services Department and administered by KS Medical/Health staff with the exception of the following:
   A Middle or High School student may be permitted to carry and self-administer a medication **only if**:

   a) Parent and prescribing health care provider (MD, DO, PA or NP) deem the student responsible to remember to take prescribed doses as directed.
   b) Prescribing health care provider certifies (by completing and signing Section II of this form), the student knows what the medication is for, when to take a dose & is able to safely self-administer the medication.
   c) The medication does **not** require refrigeration.
   d) **Controlled substances or mood disorder medications will not be allowed to be self-administered. These medications must be dispensed through Hale Ola or other dispensary for day and boarding students.**
   e) The medication is **appropriately labeled by a pharmacist or health care provider** to include:

      - ✓ student's name
      - ✓ medication name
      - ✓ quantity, dosage and time to be taken
      - ✓ date of prescription and name of prescribing health care provider

2. An Elementary school student may have the option of carrying and self-administering medications **only** for asthma, anaphylaxis, or another potential life-threatening illness. The above requirements "1 a through e" must be met. The other option is for the medications may be stored in the health room for administration by the nurse during school.

3. Parents/Legal Guardians must complete Section I.

4. The prescribing health care provider must sign & complete Section II. If the student will be self-administering an over-the-counter medication, Section II must be completed by the parent but a prescriber's signature is not required.

5. When Sections I & II are completed, return this form to the appropriate Health Services Department for approval by the Director.

6. No medication will be stored or administered by the Health Services Department without prior approval and completion of this form.

7. Upon approval of this request parents are to:

   a) Be sure the medication is in a container **labeled by the pharmacist / health care provider as required in 1e.**
   b) Remind child to report to the dispensary at the prescribed time.

8. This form will be effective for the current school year and **must be renewed annually**.

KAMEHAMEHA SCHOOLS
MĀLAMA OLA HEALTH SERVICES DEPARTMENT

REQUEST FOR ADMINISTRATION OF MEDICATION (RAM)

(One medication per form)

Student's Name: _____ _____
Last First

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

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

1. I/We, the undersigned, request and authorize Kamehameha Schools Health Services staff or their designee to administer medication, as prescribed by his/her health care provider, to my/our child named above and understand that Kamehameha Schools cannot assume the responsibility for reminding my/our child to report for his/her medication. **OR**

   ❒ **I/We deem my/our child is responsible to remember to take prescribed doses as directed, that my/our child knows what the medication is for, when to take a dose & is able to safely self-administer the medication.**
2. I/We understand that this request pertains to prescription medications as well as regularly used over-the-counter medications.
3. I/We also understand that any changes in medication or dosage must be in writing and signed by the prescribing health care provider.
4. I/We hereby release and agree to indemnify, defend and hold forever harmless the Kamehameha Schools, its trustees, representatives, agents and employees from and against any and all claims arising from personal injury and/or property damage resulting from the administration of medication consistent with this request.

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

Section II. Medication Information from Prescribing Healthcare Provider

****If your child will be self-administering an over-the-counter medication, this section must be completed, but a prescriber's signature is not required.*

Diagnosis:_____ Medication name/dose: _____

Directions for use: _____

❒ Medication to be administered by KS Health Services staff OR ☐ Allow student to self-administer

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

Name of Prescriber_____ Phone_____

Address_____

Signature of Prescriber_____ Date_____

Office Use Only

The above request has been reviewed and request approved.

_____ _____
HSM/SHD or Designee Date