STATE OF HAWAII
DEPARTMENT OF EDUCATION

VOLUNTEER AUTHORIZATION TO ADMINISTER EPINEPHRINE AND GLUCAGON

School: _____ School Year: _____

Please complete this form in black or blue ink

Student Name (Last, First):	Date of Birth:

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

Request and Authorization:

I, the undersigned, authorize Hawaii Department of Education (DOE) employees or agents who are not licensed health care providers to administer auto-injectable epinephrine and/or glucagon to my child in emergency situations as ordered by my child's prescribing health care provider.

Waiver of Liability:

NOTICE: The DOE and their employees and/or agents shall not incur any liability as a result of any injury arising from the administration of medications by a volunteer as specified on this form.

My initials and signature below indicate that:

_____ (initials) I have read and acknowledge the above notice, "Waiver of Liability." I shall indemnify and hold harmless the DOE and its employees or agents against any claims arising out of compliance with medication administration as specified on this form;

_____ (initials) I have read the instructions at the bottom of this form, "Notice to Parents/Legal Guardians and Healthcare Providers" and understand that additional documentation of medical orders is required for my child to receive the requested medication at school or during school-sponsored activities;

_____ (initials) I acknowledge this authorization shall be effective for the school year for which it is granted and shall be renewed for each subsequent school year by completing the required forms.

Parent/Legal Guardian Signature:	Parent/Legal Guardian Printed Name:	Date:

II. PHYSICIAN, ADVANCED PRACTICE REGISTERED NURSE OR PHYSICIAN ASSISTANT CERTIFICATION

I, the undersigned, certify that my medical orders provided pursuant to a completed SH36 or SH36DM form for the above named child to receive auto-injectable epinephrine or glucagon in an emergency may be administered by a volunteer. I understand that volunteers authorized to perform medication administration under this certification who are unlicensed personnel are required to receive training for the requested medication administration as permitted under Hawaii Revised Statutes, § 302A-1164.

Healthcare Provider (Please stamp or print legibly)

Name:

Phone: Fax:

Address:

Signature: _____ Date: _____

NOTICE TO PARENTS/LEGAL GUARDIANS AND HEALTHCARE PROVIDERS

Please note: DOE employees or agents who are not licensed health professionals are permitted to volunteer for emergency administration of auto-injectable epinephrine or glucagon medications with certification from the student's physician, advanced practice registered nurse, or physician assistant under Hawaii Revised Statutes, § 302A-1164. The law also requires volunteers receive instruction on the administration of these medications from a 'qualified health professional.' This may be coordinated by the DOE.

The certification provided by completing this form is only applicable if the student also has for the current school year a completed and approved form:

1. SH36DM: REQUEST FOR DIABETES CARE AND MEDICATION ADMINISTRATION with glucagon order; or
2. SH36: REQUEST TO STORE AND ADMINISTER MEDICATIONS with auto-injectable epinephrine order;

Epinephrine 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.