

**EXHIBIT H**  
**Kamehameha Schools**  
**Student Treatment Form**

Please print

Student's Name	Age	Grade
Date/time ___/___/___ am/pm	Location/activity	
Complaints/symptoms		
Medication given: Amount/dose:		
Name of adult who attended student _____		extension
Signature of adult who attended student _____		

Send to the Principal's Office or designated medical or health services staff/department (Hawaii, Kapalāma, and Maui Campuses), Regional Manager (for Preschool), or Department Director (for EED)