

ASTHMA

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2016-2017

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

Student Last Name	First Name	MI	Date of birth ___/___/_____	School
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PARENT/GUARDIAN'S CONSENT

I hereby consent to the storage and administration of medication, as well as the storage and use of necessary equipment to administer medication, in accordance with the instructions of my child's health care practitioner. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-stock inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that all provided medication must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the school nurse of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this MAF is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction program session; or such time that I deliver to the school nurse new instructions issued by my child's health care practitioner (whichever is earlier). By submitting this MAF, I am requesting that my child be provided specific health services by DOE and the New York City Department of Health and Mental Hygiene (DOHMH) through the Office of School Health (OSH). I understand that these services may include a clinical assessment and a physical examination by an OSH health care practitioner. Full and complete instructions regarding the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form.

I understand that after the MAF expiration date, an OSH health care practitioner may examine my child to evaluate his/her asthma symptoms and my child's response to the prescribed medication, and may issue a new MAF. If the OSH health care practitioner determines that no changes to the orders in the MAF are necessary, the OSH health care practitioner may issue a new MAF with the same orders to expire in one year unless my child's health care practitioner provides a new MAF. If the OSH health care practitioner determines, based on an examination of my child and pertinent medical history, that the orders in the MAF should be changed, the OSH health care practitioner may issue a new MAF with different orders to expire in one year unless my child's health care practitioner provides a new MAF. I, along with my child's health care practitioner of record, will be notified of the issuance of new MAF and of any change in the MAF orders. I further understand that I will have until 30 days before the expiration date of this MAF to submit a new MAF, or to object to this examination in writing, to the school nurse. If I do not submit a new MAF to the school nurse, or notify the school nurse in writing that I object to my child being examined by an OSH health care practitioner, by this deadline, my child may be examined and a new MAF may be issued.

I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request and consent for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I understand that OSH and DOE and their employees and agents, may contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care practitioner and/or pharmacist that has provided medical or health services to my child.

****SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications):**

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further consent to my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, and for any and all consequences of my child's use of such medication in school. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

_____ I consent to the school nurse storing and/or administering to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ I hereby certify that I have consulted with my child's health care practitioner and that I consent to the Office of School Health administering stock asthma medication in the event that my child's asthma prescription medication is unavailable.

You must send your child's Personal Metered Dose Inhaler (MDI) with your child on a school trip day in order that he/she has it available. The stock asthma medication is only for use while your child is in the school building.

Parent/Guardian's Signature		Print Parent/Guardian's Name	
Date Signed ___/___/_____		Parent/Guardian's Address	
Telephone Numbers: Daytime (____) _____ - _____		Home (____) _____ - _____	
Cell Phone* (____) _____ - _____			
Parent/Guardian e-mail address*			
Alternate Emergency Contact's Name		Contact Telephone Number (____) _____ - _____	
DO NOT WRITE BELOW - FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY			
Received by: Name		Reviewed by: Name	
Date ___/___/_____		Date ___/___/_____	
Self-Administers/Self-Carries: <input type="checkbox"/> Yes <input type="checkbox"/> No		Services provided by: <input type="checkbox"/> Nurse <input type="checkbox"/> OSH Public Health Advisor <input type="checkbox"/> School Based Health Center	
Signature and Title (RN OR MD/DO/NP):			

ALLERGIES / ANAPHYLAXIS

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH
 Authorization for Administration of Medication to Students for School Year 2016-2017

ATTACH STUDENT PHOTO HERE	Student Last Name	First Name	Middle	Date of birth MM / DD / YYYY	Weight (kg) _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
	School (include name, number, address and borough)			OSIS # _____	DOE District _____	Grade _____
				Class _____		

The following section to be completed by Student's HEALTH CARE PRACTITIONER

Specify Allergy <input type="checkbox"/> Allergy to _____	Specify Allergy <input type="checkbox"/> Allergy to _____	Specify Allergy <input type="checkbox"/> Allergy to _____
History of asthma? <input type="checkbox"/> Yes (If yes, student has an increased risk for a severe reaction) <input type="checkbox"/> No	Does this student have the ability to: Self-Manage <input type="checkbox"/> Yes <input type="checkbox"/> No	
History of anaphylaxis? <input type="checkbox"/> Yes Date ___/___/____ <input type="checkbox"/> No	Recognize signs of allergic reactions <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, symptoms <input type="checkbox"/> Respiratory <input type="checkbox"/> Skin <input type="checkbox"/> GI <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Neurologic	Recognize/avoid allergens independently <input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment _____	Date ___/___/____	Comments: _____

Select In School Medications	In School Instructions
<p>1. ONLY SINGLE DOSE AUTO-INJECTORS SELECT BELOW</p> <input type="checkbox"/> Epinephrine Auto-Injector 0.15 mg <input type="checkbox"/> Epinephrine Auto-Injector 0.3 mg <input type="checkbox"/> Give antihistamine in addition to epinephrine (must order antihistamine below) <p>Select the most appropriate option for this student:</p> <input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised Student: student self-administers, under adult supervision <input type="checkbox"/> Independent Student: student is self-carry/self-administer ** • I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events _____ <div style="text-align: right; font-size: small;">practitioner's initials</div>	<p>PRN (check all that apply):</p> <input type="checkbox"/> Itching <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Vomiting / Diarrhea <input type="checkbox"/> Hives <input type="checkbox"/> Tightness / Closure <input type="checkbox"/> Weak Pulse <input type="checkbox"/> Swelling <input type="checkbox"/> Hoarseness <input type="checkbox"/> Pallor / Cyanosis <input type="checkbox"/> Redness <input type="checkbox"/> Wheezing <input type="checkbox"/> Dizziness / Fainting <p>Specify signs, symptoms, or situations:</p> <p style="text-align: center;">➤ Administer Intramuscularly into anterolateral aspect of thigh ➤ Call 911 immediately</p> <p>If no improvement, repeat in ___ minutes for a maximum of ___ times (not to exceed a total of 3 doses).</p>

**PARENT MUST INITIAL REVERSE SIDE

<p>2. ORAL MEDICATION: <input type="checkbox"/> Diphenhydramine Preparation/Concentration: _____ Route _____</p> <p>Select the most appropriate option for this student:</p> <input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised Student: student self-administers, under adult supervision <input type="checkbox"/> Independent Student: student is self-carry/self-administer ** • I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events _____ <div style="text-align: right; font-size: small;">practitioner's initials</div>	<p>PRN (check all that apply):</p> <input type="checkbox"/> Itchy / Runny Nose <input type="checkbox"/> Itchy Mouth <input type="checkbox"/> Few Hives <input type="checkbox"/> Sneezing <input type="checkbox"/> Mildly Itchy Skin <input type="checkbox"/> Mild Nausea / Discomfort <p>Specify signs, symptoms, or situations:</p> <p>Dose: _____ q <input type="checkbox"/> 4 hours or <input type="checkbox"/> 6 hours as needed (specify) If no improvement, indicate instructions: _____</p>
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**PARENT MUST INITIAL REVERSE SIDE

<p>3. ORAL MEDICATION: _____ Preparation/Concentration: _____ Route _____</p> <p>Select the most appropriate option for this student:</p> <input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised Student: student self-administers, under adult supervision <input type="checkbox"/> Independent Student: student is self-carry/self-administer ** • I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events _____ <div style="text-align: right; font-size: small;">practitioner's initials</div>	<p>PRN Specify signs, symptoms, or situations:</p> <p>Dose: _____ Time interval: q ___ (specify min or hours) Conditions under which medication should not be given: _____</p> <p>If no improvement, indicate instructions: _____</p>
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HOME Medications (include over-the counter)	For Office of School Health (OSH) Use Only
	Revisions per OSH after consultation with prescribing practitioner. <input type="checkbox"/> IEP

Health Care Practitioner (Please Print)	LAST NAME	FIRST NAME	Signature
Address		Tel. (____) ____-____	Fax. (____) ____-____
E-mail address*		Cell* (____) ____-____	
NYS License # (Required) _____	Medicaid # _____	NPI # _____	Date ___/___/____

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*Confidential information should not be sent by e-mail.

ALLERGIES / ANAPHYLAXIS

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I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this consent is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction program session; or such time that I deliver to the school nurse a new prescription or instructions issued by my child's health care practitioner (whichever is earlier). By submitting this MAF, I am requesting that my child be provided specific health services by DOE and the New York City Department of Health and Mental Hygiene (DOHMH) through the Office of School Health (OSH). I understand that these services may include a clinical assessment and a physical examination by an OSH health care practitioner. Full and complete instructions regarding the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form.

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_____ I consent to the school nurse to storing and/or administering to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ I hereby certify that I have consulted with my child's health care practitioner and that I consent to the Office of School Health to administering stock epinephrine in the event that my child's prescribed epinephrine is unavailable.

You must send your child's epinephrine, asthma inhaler and other approved self-administered medications with your child on a school trip day and/or after-school programs in order that he/she has it available. The stock epinephrine is only for use while your child is in the school building.

Parent/Guardian's Signature		Print Parent/Guardian's Name	
Date Signed ___/___/_____		Parent/Guardian's Address	
Telephone Numbers: Daytime (____)____-_____		Home (____)____-_____	
Cell Phone* (____)____-_____			
Parent/Guardian e-mail address*			
Alternate Emergency Contact's Name		Contact Telephone Number (____)____-_____	
DO NOT WRITE BELOW - FOR OSH USE ONLY			
Received by: Name		Reviewed by: Name	
Date ___/___/_____		Date ___/___/_____	
Self-Administers/Self-Carries: <input type="checkbox"/> Yes <input type="checkbox"/> No	Services provided by: <input type="checkbox"/> Nurse <input type="checkbox"/> OSH Public Health Advisor <input type="checkbox"/> School Based Health Center <input type="checkbox"/> DOE School Staff		
Signature and Title (RN OR MD/DO/NP):			