

# 哮喘藥物施用表 (ASTHMA MEDICATION ADMINISTRATION FORM)

哮喘提供者醫療手續執行表 | 學校健康辦公室 | 2023-2024 學年

請交還給學校護士/校內健康中心。6月1日之後遞交的表格可能會對新學年的申請程序造成延誤

學生姓氏: \_\_\_\_\_ 名字: \_\_\_\_\_ 中間名首字母: \_\_\_\_\_ 出生日期: \_\_\_\_\_

性別:  男  女 學生身份號碼(OSIS): \_\_\_\_\_ 教育局學區: \_\_\_\_\_ 年級/班級: \_\_\_\_\_

學校 (包括: ATS DBN/名稱、地址和行政區): \_\_\_\_\_

## HEALTH CARE PRACTITIONERS COMPLETE BELOW

### Diagnosis

- Asthma  
 Other: \_\_\_\_\_

### Control (see NAEPP Guidelines)

- Well Controlled  
 Not Controlled / Poorly Controlled  
 Unknown

### Severity (see NAEPP Guidelines)

- Intermittent  
 Mild Persistent  
 Moderate Persistent  
 Severe Persistent  
 Unknown

### Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

- History of near-death asthma requiring mechanical ventilation  Y  N  U  
History of life-threatening asthma (loss of consciousness or hypoxic seizure)  Y  N  U  
History of asthma-related PICU admissions (ever)  Y  N  U  
Received oral steroids within past 12 months  Y  N  U \_\_\_\_\_ times last: \_\_\_\_\_  
History of asthma-related ER visits within past 12 months  Y  N  U \_\_\_\_\_ times last: \_\_\_\_\_  
History of asthma-related hospitalizations within past 12 months  Y  N  U \_\_\_\_\_ times last: \_\_\_\_\_  
History of food allergy or eczema, specify: \_\_\_\_\_  Y  N  U  
Excessive Short Acting Beta Agonist (SABA) use (daily or > 2 times a week)?  Y  N  U

### Home Medications (include over the counter) None

- Reliever: \_\_\_\_\_  Controller: \_\_\_\_\_  Other: \_\_\_\_\_

### Student Skill Level (select the most appropriate option):

- Nurse-Dependent Student: nurse must administer medication  
 Supervised Student: student self-administers, under adult supervision  
 Independent Student: student is self-carry/self-administer  
 I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school- Sponsored events. Practitioner's Initials: \_\_\_\_\_

### Quick Relief In-School Medication

**\*\* If in Respiratory Distress: call 911 and give albuterol 6 puffs: may repeat Q 20 minutes until EMS arrives!**

- Albuterol [Only generic Albuterol MDI w/ individual spacer is provided by school; this will be used if prescribed medication below is unavailable]  
**Standard Order:** Give 2 puffs q 4 hrs PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE.

Other Quick Relief Medication:

- Other Albuterol Dosing: Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Dose: \_\_\_\_\_ puffs every \_\_\_\_\_ hours. If not symptom-free within 20 mins may repeat ONCE  
 Airsupra (albuterol & budesonide) Strength \_\_\_\_\_ Dose \_\_\_\_\_ puffs PRN every \_\_\_\_\_ hrs. If not symptom-free within 20 mins may repeat ONCE  
 Symbicort (formoterol & budesonide) Strength: \_\_\_\_\_ Dose: \_\_\_\_\_ puffs every \_\_\_\_\_ min or \_\_\_\_\_ hrs.  May repeat ONCE PRN  
 Albuterol with ICS:  Albuterol \_\_\_\_\_ puffs followed by Flovent \_\_\_\_\_ puffs every \_\_\_\_\_ hrs. If not symptom-free in 20 mins may repeat ONCE  
• Albuterol \_\_\_\_\_ puffs followed by Qvar \_\_\_\_\_ puffs every \_\_\_\_\_ hrs. If not symptom-free in 20 mins may repeat ONCE  
 Albuterol MDI \_\_\_\_\_ puffs followed by ICS (Name) \_\_\_\_\_ Strength: \_\_\_\_\_ puffs every \_\_\_\_\_ hrs  
 URI Symptoms/Recent Asthma Flare: 2 puffs @noon for 5 school days when directed by PCP  
Name: \_\_\_\_\_ Dose: \_\_\_\_\_ puffs/ \_\_\_\_\_ AMP q \_\_\_\_\_ hrs.  
 Pre-exercise: Name: \_\_\_\_\_ Dose: \_\_\_\_\_ puffs/ \_\_\_\_\_ AMP 15-20 mins before exercise.

### Special Instructions:

### Controller Medications for In-School Administration (Recommended for Persistent Asthma, per NAEPP Guidelines)

- Fluticasone [Only Flovent® 110 mcg MDI is provided by school for shared usage]  Stock  Parent Provided  
Standing Daily Dose: \_\_\_\_\_ puff (s)  one **OR**  two time(s) a day Time: \_\_\_\_\_ AM and \_\_\_\_\_ PM  
 Symbicort (provided by parent). Standing Daily Dose: \_\_\_\_\_ puff (s)  one **OR**  two time(s) a day Time: \_\_\_\_\_ AM and \_\_\_\_\_ PM Special Instructions: \_\_\_\_\_  
 Other ICS (provided by parent) Standing Daily Dose:  
Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency:  one **OR**  two time(s) a day Time: \_\_\_\_\_ AM & \_\_\_\_\_ PM

### Health Care Practitioner

Last Name (Print): \_\_\_\_\_ First Name (Print): \_\_\_\_\_  MD  DO  NP  PA

NYS License # \_\_\_\_\_ NPI #: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Completed by Emergency Department Medical Practitioner:  Yes  No (ED Medical Practitioners will not be contacted by OSH/SBHC Staff)

Address: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Tel: \_\_\_\_\_ FAX: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.**

FORMS CANNOT BE COMPLETED BY A RESIDENT  
INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS.

| REV 3/23

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家長/監護人通讀、填寫並簽名。我在下面簽名，表示我同意如下：

- 我同意，學校保存我子女的醫藥並根據我子女的保健專業人員的說明給藥。我也同意，我子女的醫藥所需的任何器材都在學校裏儲存和使用。
- 我理解：
  - 我必須把我子女的醫藥和器材（包括非羈甲異丁腎上腺素albuterol吸入器）交給學校護士/校內健康中心（SBHC）。
  - 我給予學校的所有處方和非處方藥物都必須是新的、未曾開封過並裝在其原封瓶子或盒子裏。我將給學校提供我子女在上學日內需使用的當前、未過期的醫藥用品。
    - 處方藥物必須在其盒子或瓶子上有原裝藥房標籤。標籤必須包括：1) 我子女的姓名；2) 藥房名稱和電話號碼；3) 我子女的保健專業人員的名稱；4) 日期；5) 重配次數；6) 藥物名稱；7) 劑量；8) 何時用藥；9) 如何用藥；10) 任何其他說明。
  - 我謹此證明/確認，我已諮詢我子女的保健專業人員，並且我同意學校健康辦公室/SBHC在萬一我子女沒有哮喘藥物之際可以給我子女施用儲存的藥物。
  - 如果我子女的藥物發生任何變化或者醫生的說明有任何變化，我必須立即告知學校護士/SBHC提供者。
  - 涉及到給我子女提供上述健康服務的學校健康辦公室（OSH）及其代理人依賴於本表資訊的精確度。
  - 我在這一「藥物施用表」（Medication Administration Form, 簡稱MAF）上簽名，表示授權學校健康辦公室（Office of School Health, 簡稱OSH）/SBHC為我子女提供健康服務。這些服務可以包括（但不限於）由一名OSH辦公室/SBHC保健專業人員或護士所執行的臨床評估或體檢。
  - 這份MAF表的醫療執行手續的過期時間是我子女的學年結束（這可能包括暑期班）或者當我交給學校護士/SBHC提供者一份新的MAF（取兩者中較早的那個時間）。
  - 當這份醫療手續執行要求過期時，我將給我子女的學校護士/SBHC提供者一份新的由我子女的保健專業人員出具的MAF。如果這一點沒有做到，一名OSH/SBHC保健專業人員可以檢查我子女，除非我給學校護士/SBHC出具一封信函，信函上說明我不希望OSH/SBHC保健專業人員檢查我子女。OSH/SBHC保健專業人員可以評估我子女的哮喘症狀及其對處方哮喘藥物的反應。OSH/SBHC保健專業人員可以決定該醫療手續執行是否將維持原狀或者需要做出改變。OSH/SBHC保健專業人員可以填寫一份新的MAF，這樣我的子女可以繼續接受OSH所提供的健康服務。我的保健專業人員或OSH/SBHC保健專業人員將不需要我的簽名來出具以後的哮喘MAF。如果OSH/SBHC保健專業人員為我子女填寫一份新的MAF，OSH/SBHC保健專業人員將盡其努力通知我和我子女的保健專業人員。
  - 這份表格代表我對本表所說明的哮喘服務的同意和要求。這並非OSH/SBHC提供所要求的服務的協議。如果OSH/SBHC決定提供這些服務，我子女可能還需要一份「第504款特別照顧計劃」（Section 504 Accommodation Plan）。這份計劃將由學校填寫。
  - 為著給我子女提供護理或治療的目的，OSH/SBHC可以獲取該辦公室認為有關我子女的醫療狀況、藥物和治療而需要的任何其他資訊。OSH/SBHC可以向任何為我子女提供健康服務的保健專業人員、護士或藥劑師索取該資訊。

自己用藥（僅適用於能自己獨立用藥的學生）：

- 我證明/確認，我子女已得到完全的訓練並能夠自行用藥。我同意，我子女在學校裏自己攜帶、儲存本表所開具的藥物並將自己用藥。我負責根據上述說明把瓶子或盒子裏的藥物交給我子女。我也負責監督我子女在學校裏的藥物使用情況及其對這一藥物使用所導致的任何後果。學校護士/SBHC將確認我子女擁有攜帶和自行用藥的能力。我也同意交給學校「備用」藥物（裝在清楚地標示的盒子或瓶子裏）。  
註：如果您選擇使用儲存的藥物，則您必須在您子女參加學校外出參觀的日子以及/或者課後計劃時讓子女帶上哮喘吸入器、epinephrine以及其他獲准的自我施用藥物，以備您子女使用。儲存藥物只能由OSH員工在學校使用。

Student Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Date of birth: \_\_\_\_\_

School (ATS DBN/Name): \_\_\_\_\_ Borough: \_\_\_\_\_ District: \_\_\_\_\_

Parent/Guardian Name (Print): \_\_\_\_\_ Parent/Guardian's Email: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_

Parent/Guardian Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Other Emergency Contact Name/Relationship: \_\_\_\_\_

Other Emergency Contact Phone: \_\_\_\_\_

For Office of School Health (OSH) Use Only

OSIS Number: \_\_\_\_\_ Received by - Name: \_\_\_\_\_ Date: \_\_\_\_\_

504  IEP  Other \_\_\_\_\_ Reviewed by - Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referred to School 504 Coordinator:  Yes  No

Services provided by:  Nurse/NP  OSH Public Health Advisor (for supervised students only)

School Based Health Center  OSH Asthma Case Manager (For supervised students)

only) Signature and Title (RN OR MD/DO/NP): \_\_\_\_\_

Revisions per Office of School Health after consultation with prescribing practitioner:  Clarified  Modified

Confidential information should not be sent by email

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