Attach student photo here

過敏/過敏反應症藥物施用表

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申請程序造成延誤

學生姓氏：_____ 名字：_____ 中間名_____ 出生日期：_____

性別： ☐男 ☐ 女 學生身份號碼(OSIS)：_____ 體重：___

學校（包括名稱、號碼、地址和行政區）：

教育局學區：____ 年級：_____班級：_____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergies: _____

History of asthma? ☐ Yes (If yes, student has an increased risk for a severe reaction; complete the Asthma MAF for this student) ☐ No

History of anaphylaxis? ☐ Yes Date: _____ ☐ No

If yes, system affected ☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic

Treatment: _____Date: _____

Does this student have the ability to:

Self-Manage (See 'Student Skill Level' below) ☐ Yes ☐ No

Recognize signs of allergic reactions ☐ Yes ☐ No

Recognize and avoid allergens independently ☐ Yes ☐ No

Select In-School Medications

SEVERE REACTION

A. Immediately administer epinephrine ordered below, then call 911.

☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg

Give intramuscularly in the anterolateral thigh for any of the following signs/symptoms (retractable devices preferred) :

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Feeling of doom, confusion, altered consciousness or agitation

☐ Other: _____

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____

Even if child has MILD signs/symptoms after a sting or eating these foods, give epinephrine and call 911.

B. If no improvement, or if signs/symptoms recur, repeat in _____ minutes for maximum of _____times (not to exceed a total of 3 doses)

☐ If this box is checked, give antihistamine after epinephrine administration (order antihistamine below) **Student Skill Level (select the most appropriate option):**

☐ Nurse-Dependent Student: nurse/trained staff must administer

☐ 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: _____

MILD REACTION (parent must supply medicine for use in medical room)

A. For any of the following sign and symptoms_____, give:

- Benadryl _____mg po Q6 hours prn
- Name: _____Preparation/Concentration:_____ Dose: _____ PO ☐Q4 hours ☐Q6 hours ☐Q12 hours prn

Student Skill Level (select the most appropriate option):

☐ Nurse-Dependent Student: nurse must administer

☐ 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: _____

OTHER MEDICATION

- Give Name:_____Preparation/Concentration:_____Dose:_____ PO Q_____ hours prn

Specify signs, symptoms, or situations: _____

If no improvement, indicate instructions:_____

Conditions under which medication should not be given:_____

Student Skill Level (select the most appropriate option):

☐ Nurse-Dependent Student: nurse must administer

☐ 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: _____

Home Medications (include over the counter) ☐ None

Health Care Practitioner

Last Name (Print):_____ First Name (Print): _____Signature: _____

NYS License # (Required): _____ NPI #: _____**Please check one:** ☐ MD ☐ DO ☐ NP ☐ PA Date: _____

Address: _____E-mail address: _____

Tel: _____ FAX: _____ Cell Phone: _____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 3/23**家長必須在第2頁簽名 ➔**

過敏/過敏反應症藥物施用表

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

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：

1. 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。
2. 我理解：
   - 我必須把我子女的醫藥和器材交給學校護士/校內健康中心（SBHC）提供者。我將儘量給學校有伸縮針頭的腎上腺素注射器（Iepinephrine pens with retractable needles）。
   - **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在萬一我子女沒有哮喘藥物或腎上腺素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保健專業人員的說明有任何變化，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）及其代理人員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）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,我將交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。
   - 這份表格代表我對本表所說明的過敏服務的同意和要求。這並非OSH提供所要求的服務的協議。如果OSH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。
   - 爲著給我子女提供護理或治療的目的，OSH可以獲取該辦公室認爲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提供者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）。
- 我同意，如果我子女臨時不能攜帶或自行用藥，學校護士或經過訓練的學校員工可以給我子女施用腎上腺素。

註：如果您決定使用儲存的藥物，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epinephrine、哮喘吸入器以及其他獲准的自我施用藥物，以備您子女使用。儲存的藥物只是由OSH員工在學校使用。

學生姓氏：_____ 名字：_____ 中間名：____ 出生日期：_____

學校（ATS DBN/名稱）：_____ 行政區：_____ 學區：_____

家長/監護人姓名（用英文清楚書寫）：_____ 家長/監護人電子郵箱：_____

家長/監護人簽名：_____ 簽名日期：_____

家長/監護人地址：_____

家長 / 監護人手機號碼：_____ 其他電話 _____

其他緊急聯絡人姓名/關係：_____

其他緊急聯絡人電話：_____

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

Signature and Title (RN OR SMD):_____

Date School Notified & Form Sent to DOE Liaison:_____

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

Confidential information should not be sent by email FOR PRINT USE ONLY