MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

THIS FORM SHOULD BE USED FOR NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY

Authorization for Administration of Medication to Students for School Year **2016–2017**

家長/監護人同意信

我謹此授權藥物的儲藏和施用以及根據我子女的保健專業人員的指導為施用該藥物而必需的器械的儲藏和使用。我理解，我必須給學校提供施用藥物所必需的藥物和器械（包括非 Ventolin 吸入器）。藥物應置於一個來自藥房並正確標示的原裝容器（我應為我子女在學校之外的使用另外配得一個如此的容器）；處方藥物的標示必須包含學生姓名、藥房名稱和電話號碼、執照開處方醫生的姓名和日期及再拿葯的次數、藥物的名稱和劑量及施用頻率、施用規程和/或其他說明；櫃檯購買的藥品和藥物樣本必須裝在藥廠原裝的容器裏，容器上附有學生姓名。我理解，我所提供的所有藥物都必須以其原裝和**未開封**的藥物包裝盒提供。我也理解，如果上述涉及的處方或說明出現任何變化，我必須立即通知學校護士。

我理解，學生不得攜帶或自己施用任何控制藥物（controlled substances）。

我理解，這份同意函的有效期只持續到一個由紐約市教育局（DOE）資助的暑期教學計劃時段結束爲止，或者到我將我子女的保健專業人員簽發的最新處方或說明交給學校護士這一時間爲止（以這兩者中較早的時間為准）。我遞交這份MAF表格，則表明我申請由教育局（DOE）以及紐約市健康和心理衛生局（New York City Department of Health and Mental Hygiene，簡稱DOHMH）通過學校健康辦公室（Office of School Health，簡稱OSH）給我的子女提供具體健康服務。我理解，這些服務可能包括由一名OSH辦公室的保健專業人員所執行的一次臨床評估和一次體檢。關於上述所要求的健康服務的全面和完整的說明列入此MAF表。我理解，與上述要求的健康服務的提供相關的學校健康辦公室及其代理機構和僱員需要本表格所提供資訊的精確性。我知道，這一表格並不是教育局以及健康和心理衛生局（DOHMH）提供所申請的服務的同意函，而是我要求這些服務的申請和同意函。如果這些服務被確定為有必要，則也可能需要制訂一份《學生照顧計劃》（Student Accommodation Plan），該計劃將由學校制訂。我理解，教育局、學校健康辦公室及其僱員和代理機構可以與任何給我子女提供醫療或健康服務的保健專業人員和/或藥劑師聯絡和協商並獲取任何他們認爲與我子女的醫療狀況、藥物和/或療法相關的恰當額外資訊。

學生自己用藥：請在這段簽上您姓名的首字母，讓您的子女可以自己使用epinephrine、哮喘吸入器及其他經批准可自己使用的藥物：

____ 謹此證明，我的子女已經獲得全面的指導，有能力自己施用該處方藥物。我也同意我子女在學校攜帶、儲藏和自己使用上述處方藥物。我知道，我要負責給我的子女提供如此藥物：該藥物必須置於如以上所描述而標示的容器中；我要負責對我子女使用此藥物的任何和所有的監督；並負責我子女因在學校使用此藥物而導致的任何或所有後果。我理解，學校護士將確認我子女是否具有以負責的方式自己攜帶和自己施用藥物的能力。另外，我同意提供一份置於一個清楚標寫的容器中的「後備」藥物，該藥物將被保存在醫務室，在我子女沒有足夠藥物自己施用的情況下備用。

____ 我同意，萬一我的子女臨時無法自己儲藏和自己施用該藥物時，學校護士可以儲存此藥物和/或給我的子女施用該藥物。

_____ **我謹此證明，我已諮詢我子女的保健專業人員，並且我授權學校健康辦公室在我子女沒有哮喘處方藥物可使用時施用儲存的萬托林（Ventolin）。**

家長/監護人簽名	**清楚填寫家長/監護人的姓名**
簽名日期 ＿＿/＿＿/＿＿＿＿	**家長/監護人地址**
電話號碼： **日間**（＿＿＿）＿＿＿- ＿＿＿＿ **住宅**（＿＿＿）＿＿＿- ＿＿＿＿ **手機**（＿＿＿）＿＿＿- ＿＿＿＿	
其他緊急聯絡人姓名	**聯絡電話**（＿＿＿）＿＿＿- ＿＿＿＿
DO NOT WRITE BELOW – FOR DOE AND OSH ONLY	
Received by:Name Date ＿＿/＿＿/＿＿＿＿	**Reviewed by**:Name Date ＿＿/＿＿/＿＿＿＿
Referred to School 504 Coordinator:☐ Yes ☐ No	**Self-Administers/Self-Carries:**☐ Yes ☐ No
Services provided by: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center	
Signature and Title (RN OR MD/DO/NP):	**Date School Notified & Form Sent to DOE Liaison** ＿＿/＿＿/＿＿＿＿

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ATTACH STUDENT PHOTO HERE	**Student** Last Name First Name Middle	**Date of birth** __/__/____ MM DD YYYY	☐ Male ☐ Female
	Guardian's e-mail address	**OSIS Number** _ _ _ _ _ _ _ _ _	
	School (include name, number, address and borough)	**DOE District** ___ ___	**Grade** / **Class**

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

1. Diagnosis: _____ ICD-10 Code ☐ _ _ _ . _ _ _

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Select the most appropriate option for this student:

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**
  - I attest student demonstrated the ability to self-administer the prescribe medication effectively for school/field trips/school-sponsored events. _____ practitioner's initials

**** PARENT MUST INITIAL REVERSE SIDE**

In School Instructions

☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM

AND/OR

☐ PRN

_____
specify signs, symptoms, or situations

☐ Time interval: q _ _ minutes or q _ _ hours as needed.

☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

2. Diagnosis: _____ ICD-10 Code ☐ _ _ _ . _ _ _

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Select the most appropriate option for this student:

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**
  - I attest student demonstrated the ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events. _____ practitioner's initials

**** PARENT MUST INITIAL REVERSE SIDE**

In School Instructions

☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM

AND/OR

☐ PRN

_____
specify signs, symptoms, or situations

☐ Time interval: q _ _ minutes or q _ _ hours as needed.

☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

3. Diagnosis: _____ ICD-10 Code ☐ _ _ _ . _ _ _

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Select the most appropriate option for this student:

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**
  - I attest student demonstrated the ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events._____ practitioner's initials

**** PARENT MUST INITIAL REVERSE SIDE**

In School Instructions

☐ Standing daily dose: at _ _: _ _ am / pm and _ _: _ _ AM / PM

AND/OR

☐ PRN

_____
specify signs, symptoms, or situations

☐ Time interval: q _ _ minutes or q _ _ hours as needed.

☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

HOME Medications (include over-the counter)	**For Office of School Health (OSH) Use Only**
	Revisions per OSH after consultation with prescribing health care practitioner. ☐ IEP

Health Care Practitioner LAST NAME FIRST NAME (Please Print)		Signature	
Address		Tel. No. (_ _ _)_ _ _- _ _ _ _	Fax. No (_ _ _)_ _ _- _ _ _ _
E-mail address*		Cell phone* (_ _ _)_ _ _- _ _ _ _	
NYS License No **(Required)** _ _ - _ _ _ _ _ _ _ _	Medicaid No _ _ _ _ _ _ _ _ _ _	NPI No. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	Date __ __/ __ __/ __ __ __ __

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

*Confidential information should not be sent by e-mail

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