

Medical Forms Packet

2016-2017

للحصول على ترجمات لهذه الوثائق، يرجى زيارة الموقع الإلكتروني المدرج أدناه.	Pour obtenir la traduction de ces documents, merci de visiter le site internet cité ci-dessous.	Переводы документов на русский язык находятся на нижеуказанном сайте.
এসব নথির অনুবাদ পেতে হলে অনুগ্রহ করে নিচে উল্লিখিত ইন্টারনেট সাইটে দেখুন।	Pou ka jwenn kopi dokiman sa yo an Kreyòl Ayisyen, ale sou sit entènèt ki pi ba a	Para obtener una versión de estos documentos en español, por favor visite el sitio de Internet a continuación.
如要取得文件的中文翻譯，請瀏覽下面的網站。	이들 문서의 번역본을 원하시면, 아래 기재된 인터넷 사이트를 방문하십시오.	ان دستاویزات کے ترجمہ کو حاصل کرنے کے لیے، برائے مہربانی ذیل میں درج انٹرنیٹ ویب سائٹ پر جائیں:

<http://schools.nyc.gov/Offices/Health/SchoolHealthForms>



Department of
Education

GUIDELINES FOR THE PROVISION OF HEALTH SERVICES AND/OR SECTION 504 ACCOMMODATIONS FOR STUDENTS IN NEW YORK CITY PUBLIC SCHOOLS - SCHOOL YEAR 2016-2017

To All Parents, Physicians, and Health Care Providers:

The New York City Department of Education and the New York City Department of Health and Mental Hygiene's Office of School Health work collaboratively to make certain that all students with special needs are provided services to ensure their full participation in the educational setting. To this end, parents and providers must use the enclosed forms to request in school direct health services and/or accommodations under Section 504 of the Rehabilitation Act of 1973. **These forms must be returned to the child's school for processing.** A new request and authorization form will be required for each school year if the child continues to require the requested services in school. The following guidelines should be followed in order to facilitate the review of the completed forms and to provide clinically appropriate services:

- The physician/health care provider completing the form should be the one who will actively manage the condition for which services are requested.
- A valid New York State, New Jersey or Connecticut license, Medicaid & NPI number must be provided. If a physician-in-training without a license number completes the form, it must be counter-signed by a supervisor (e.g., attending physician) and include the supervisor's license number.
- The order should be specific, legible and clearly written so that it is completely understandable to the nurse and can be carried out in a clinically responsible way.
- Only those services that must be performed during school hours should be requested, (e.g., if medication can be given at home before or after school hours, it should not be requested in school).
- Homeopathic medications will not be administered.
- Please note that medication is typically stored in a locked cabinet in a designated room (i.e., medical room) unless the student is authorized by you to carry medication in school. In addition, Epinephrine may be stored in the classroom and transported with students according to the Allergy Response Plan.
- Parents, physicians, school staff and students must work together to encourage each child to be as self-sufficient as possible. If the child is able to self-administer the medication, the parent should initial the appropriate area on the back of the medication form. Most students at the intermediate and high school level should be self-directed in taking medications, (i.e., identify the following: that the medication is the correct one; what the medication is for; that the correct dosage or amount is being administered; when the medication is needed during the school day; describe what will happen if it is not taken). Those students are then permitted to carry and self-administer only those medications that are necessary during the school day without supervision; however, **students are never permitted to carry controlled substances.**

Parents, remember to attach a small current photograph of your child to the upper left corner of the Medication Administration Form (MAF) for proper identification.

There are four types of request and authorization forms:

- Medication Administration Forms (MAFs) - should be completed only for requests involving administration of medication for students. For cases of asthma, providers may attach an Asthma Action Plan with the MAF. Use of nebulizers on school trips can be cumbersome, please consider prescribing inhaler and spacer whenever possible. **Please note that there are three separate MAFs: one for asthma medications, one for allergies/anaphylaxis medications, and one for other medications.**
- Provision of Medically Prescribed Treatment (Non-Medication) - should be completed when requesting special procedures such as bladder catheterization, postural drainage, tracheal suctioning, gastrostomy tube feeding, etc. This form may be used for all skilled nursing treatments.
- Diabetes Medication Administration Form - should be completed for students with Diabetes who require any of the following: glucose monitoring, insulin and/or glucagon administration.
- Request for Section 504 Accommodation(s) - should be used when requesting special services such as a barrier-free building, elevator use, testing modification, etc. This form should **NOT** be used for Related Services such as occupational therapy, physical therapy, speech and language therapy, counseling, etc. which is properly addressed and provided by a student's Individualized Education Program (IEP). Please note that starting in school year 2016-2017 there is a separate Medical Review for 504 accommodation form.

Please contact the student's school if you have any questions. Thank you for your assistance.

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**

ATTACH STUDENT PHOTO HERE

Student Last Name	First Name	Middle	Date of birth	<input type="checkbox"/> Male
			MM / DD / YYYY	<input type="checkbox"/> 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 <input type="checkbox"/> _____ Medication: _____ <small>Generic and/or Brand Name</small> Preparation/Concentration: _____ Dose: _____ Route: _____ Select the most appropriate option for this student: <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 (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. _____ <small>practitioner's initials</small> ** PARENT MUST INITIAL REVERSE SIDE	In School Instructions <input type="checkbox"/> Standing daily dose: at __: __ AM / PM and __: __ AM / PM AND/OR <input type="checkbox"/> PRN _____ <small>specify signs, symptoms, or situations</small> <input type="checkbox"/> Time interval: q __ minutes or q __ hours as needed. <input type="checkbox"/> If no improvement, repeat in __ minutes or __ hours for a maximum of __ times. Conditions under which medication should not be given: _____
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2. Diagnosis: _____ ICD-10 Code <input type="checkbox"/> _____ Medication: _____ <small>Generic and/or Brand Name</small> Preparation/Concentration: _____ Dose: _____ Route: _____ Select the most appropriate option for this student: <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 (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. _____ <small>practitioner's initials</small> ** PARENT MUST INITIAL REVERSE SIDE	In School Instructions <input type="checkbox"/> Standing daily dose: at __: __ AM / PM and __: __ AM / PM AND/OR <input type="checkbox"/> PRN _____ <small>specify signs, symptoms, or situations</small> <input type="checkbox"/> Time interval: q __ minutes or q __ hours as needed. <input type="checkbox"/> If no improvement, repeat in __ minutes or __ hours for a maximum of __ times. Conditions under which medication should not be given: _____
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3. Diagnosis: _____ ICD-10 Code <input type="checkbox"/> _____ Medication: _____ <small>Generic and/or Brand Name</small> Preparation/Concentration: _____ Dose: _____ Route: _____ Select the most appropriate option for this student: <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 (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. _____ <small>practitioner's initials</small> ** PARENT MUST INITIAL REVERSE SIDE	In School Instructions <input type="checkbox"/> Standing daily dose: at __: __ am / pm and __: __ AM / PM AND/OR <input type="checkbox"/> PRN _____ <small>specify signs, symptoms, or situations</small> <input type="checkbox"/> Time interval: q __ minutes or q __ hours as needed. <input type="checkbox"/> If no improvement, repeat in __ minutes or __ hours for a maximum of __ times. Conditions under which medication should not be given: _____
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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 health care practitioner. <input type="checkbox"/> IEP

Health Care Practitioner (Print)	LAST NAME	FIRST NAME	(Please	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

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**

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-Ventolin 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 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. I recognize that this form is not an agreement by the Department or DOHMH 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 the Department, DOHMH 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 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 authorize the Office of School Health to administer stock Ventolin in the event that my child's asthma prescription medication is unavailable.

Parent/Guardian's Signature	Print Parent/Guardian's Name
Date Signed ___/___/____	Parent/Guardian's Address
Telephone Numbers: Daytime (____) _____ - _____ Home (____) _____ - _____ Cell Phone (____) _____ - _____	
Alternate Emergency Contact's Name	Contact Telephone Number (____) _____ - _____
DO NOT WRITE BELOW – FOR DOE AND OSH ONLY	
Received by: Name _____ Date ___/___/____	Reviewed by: Name _____ Date ___/___/____
Referred to School 504 Coordinator: <input type="checkbox"/> Yes <input type="checkbox"/> No	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):	Date School Notified & Form Sent to DOE Liaison ___/___/____

ASTHMA

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 ____/____/____ M M D D Y Y Y Y	<input type="checkbox"/> Male <input type="checkbox"/> Female
	School (include name, number, address and borough)			DOE District	Grade

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY STUDENT'S HEALTH CARE PRACTITIONER

Diagnosis	Select Asthma Severity and Control				
<input type="checkbox"/> Asthma	Severity:	<input type="checkbox"/> Intermittent	<input type="checkbox"/> Mild Persistent	<input type="checkbox"/> Moderate Persistent	<input type="checkbox"/> Severe Persistent
Other:	Control:	<input type="checkbox"/> Well-controlled		<input type="checkbox"/> Poorly Controlled (includes Not Controlled category)	

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

History of near-death asthma requiring mechanical ventilation	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	History of asthma-related:
History of life-threatening asthma (e.g., with loss of consciousness or with hypoxic seizure)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	PICU admissions (ever)
Received oral steroids within past 12 months: ____ times	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	ER visits within past 12 months: ____ times
Date last oral steroids received: ____/____/____				Hospitalizations within past 12 months: ____ times
History of food allergy, eczema, specify _____	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	

Select In School ASTHMA Medications

In School Instructions

<p>1. Quick Relief Medications Choose ONLY one:</p> <p><input type="checkbox"/> Albuterol [Ventolin® can be provided by school for shared usage (plus individual spacer): see back]. <input type="checkbox"/> MDI with spacer <input type="checkbox"/> DPI</p> <p><input type="checkbox"/> Other Medication Order: Name: _____ Dose: _____ Route: _____ Instructions: Time interval: q ____ hours</p>	<p><input type="checkbox"/> Standard Order: Give 2 puffs q 4 hours PRN for coughing, wheezing, tightness in chest, difficulty breathing or shortness of breath ("Asthma Flare Symptoms"). Monitor for 20 minutes or until symptom-free. If not symptom-free after 20 minutes may repeat ONCE</p> <p style="text-align: center;">OR</p> <p>If in Respiratory distress*: call 911 and give 6 puffs; then may repeat 6 puffs q 20 minutes until EMS arrives.</p> <p><input type="checkbox"/> Pre-exercise: give 2 puffs 15 -20 minutes before exercise.</p> <p><input type="checkbox"/> URI symptoms or recent asthma flare (within 5 days): give 2 puffs @ noon for 5 days.</p>
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<p>2. Controller Medications for In-School Administration <i>(Recommended for Persistent Asthma, per NAEPP Guidelines)</i> SPECIFY Name(s) of medication</p> <p><input type="checkbox"/> Inhaled corticosteroid (ICS): _____ Strength _____ <input type="checkbox"/> MDI with spacer <input type="checkbox"/> DPI</p> <p><input type="checkbox"/> Other: _____ Strength _____ Dose: _____ Route: _____ Time interval: q _____</p>	<p><input type="checkbox"/> Standing daily dose: ____ puffs <i>once a day</i> at ____ AM OR ____ PM OR ____ puffs <i>twice a day</i> at ____ AM and ____ PM</p> <p><u>Special Instructions:</u></p>
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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:**

* 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**

HOME Medications (include over-the counter)	For Office of School Health (OSH) Only
	Revisions per OSH after consultation with prescribing practitioner. <input type="checkbox"/> IEP
	*Respiratory Distress: includes breathlessness at rest, tachypnea, cyanosis, pallor, hunching forward, nasal flaring, accessory respiratory muscle use, abdominal breathing, shallow rapid breathing, talking in words, wheezing throughout expiration and inspiration or decreased or absent breath sounds, agitation, drowsiness, confusion or exceptionally quiet appearance.

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

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

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	Weight (kg)	<input type="checkbox"/> Male <input type="checkbox"/> Female
				MM / DD / YYYY	____ . ____	
	School (include name, number, address and borough)			OSIS #	DOE District	Grade

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

Specify Allergy	Specify Allergy	Specify Allergy
<input type="checkbox"/> Allergy to	<input type="checkbox"/> Allergy to	<input type="checkbox"/> Allergy to
History of asthma?	<input type="checkbox"/> Yes (<i>If yes, student has an increased risk for a severe reaction</i>)	<input type="checkbox"/> No
History of anaphylaxis?	<input type="checkbox"/> Yes Date ___/___/____	<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	Does this student have the ability to:
Treatment	Date ___/___/____	Self-Manage <input type="checkbox"/> Yes <input type="checkbox"/> No
History of skin testing?	<input type="checkbox"/> Yes (attach copy of results) Date ___/___/____	Recognize signs of allergic reactions <input type="checkbox"/> Yes <input type="checkbox"/> No
		Recognize/avoid allergens independently <input type="checkbox"/> Yes <input type="checkbox"/> No
		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 ** <p><input type="checkbox"/> I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events _____ <small style="margin-left: 250px;">practitioner's initials</small></p> <p>**PARENT MUST INITIAL REVERSE SIDE</p>	<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="margin-left: 40px;">➤ 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>

<p>2. ORAL MEDICATION: <input type="checkbox"/> Diphenhydramine</p> <p>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 ** <p><input type="checkbox"/> I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events _____ <small style="margin-left: 250px;">practitioner's initials</small></p> <p>**PARENT MUST INITIAL REVERSE SIDE</p>	<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)</p> <p>If no improvement, indicate instructions:</p>
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<p>3. ORAL MEDICATION: _____</p> <p>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 ** <p><input type="checkbox"/> I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events _____ <small style="margin-left: 250px;">practitioner's initials</small></p> <p>**PARENT MUST INITIAL REVERSE SIDE</p>	<p>PRN Specify signs, symptoms, or situations:</p> <p>Dose: _____ Time interval: q ___ (specify min or hours)</p> <p><u>Conditions under which medication should not be given:</u></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 ___/___/____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

ALLERGIES / ANAPHYLAXIS

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

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 the 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-Ventolin 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 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.

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 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 _____	Date ___/___/_____	Reviewed by: Name _____	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):			

DIABETES MEDICATION ADMINISTRATION FORM – OFFICE OF SCHOOL HEALTH
Authorization for Administration of Medication in School to Students for School Year

Student Last Name		First Name		Middle	Date of birth <u> </u> / <u> </u> / <u> </u> M M D D Y Y Y Y	<input type="checkbox"/> Male	OSIS #																		
School (include name, number, address and borough)					DOE District	Grade	Class																		
<input type="checkbox"/> Type 1 Diabetes		<input type="checkbox"/> Type 2 Diabetes		<input type="checkbox"/> Other Diagnosis:		Recent A1C: Date <u> </u> / <u> </u> / <u> </u> Result <u> </u> %																			
EMERGENCY ORDERS					BLOOD GLUCOSE (bG) MONITORING																				
Severe Hypoglycemia Administer Glucagon and call 911 <input type="checkbox"/> 1 mg SC/IM <input type="checkbox"/> <u> </u> mg SC/IM Give PRN: unconsciousness, unresponsiveness, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration.					Risk for Diabetic Ketoacidosis (DKA) <input type="checkbox"/> Test ketones if hyperglycemic, vomiting, or fever ≥ 100.5 > If small or trace give water; re-test ketones & bG in <u> </u> hrs > If initial or retest ketones are moderate or large , give water <input type="checkbox"/> Call parent and PMD <input type="checkbox"/> No Gym <input type="checkbox"/> If vomiting, unable to take PO, and MD not available, CALL 911 <input type="checkbox"/> Give insulin correction dose if > <u> </u> hours since last insulin.																				
					<input type="checkbox"/> Student may check bG without nurse supervision. <input type="checkbox"/> Student to check bG with nurse supervision. <input type="checkbox"/> Nurse / school personnel must check bG.																				
					INSULIN ADMINISTRATION																				
					<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: Self-carry / Self-administer: 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																				
MONITORING		<input type="checkbox"/> At LUNCH Time		<input type="checkbox"/> At SNACK Time**		<input type="checkbox"/> At GYM Time		PRN																	
Hypoglycemia		For bG < <u> </u> mg/dL Give <u> </u> oz juice, or <u> </u> glucose tabs, or <u> </u> grams carbs. Re-check in <u> </u> minutes; if bG < <u> </u> repeat carbs and re-check until bG > <u> </u>. THEN Insulin is given BEFORE Lunch, unless otherwise indicated. <input type="checkbox"/> Give insulin AFTER Lunch Use pre-treatment bG to calculate insulin dose, unless otherwise prescribed		For bG < <u> </u> mg/dL Give <u> </u> oz juice, or <u> </u> glucose tabs, or <u> </u> grams carbs. Re-check in <u> </u> minutes; if bG < <u> </u> repeat carbs and re-check until bG > <u> </u>. THEN Insulin is given BEFORE Snack, unless otherwise indicated. <input type="checkbox"/> Give insulin AFTER Snack**		For bG < <u> </u> mg/dL Give <u> </u> oz juice, or <u> </u> glucose tabs, or <u> </u> grams carbs. Re-check in <u> </u> minutes; if bG < <u> </u> repeat carbs and re-check until bG > <u> </u>. <input type="checkbox"/> If initial bG < <u> </u> , No Gym <input type="checkbox"/> Give Snack** AFTER treatment THEN send to Gym		For bG < <u> </u> mg/dL Give <u> </u> oz juice, or <u> </u> glucose tabs, or <u> </u> grams carbs. Re-check in <u> </u> minutes; if bG < <u> </u> repeat carbs and re-check until bG > <u> </u>. <input type="checkbox"/> Give Snack** AFTER treatment																	
Between hypo & hyperglycemia		Insulin is given BEFORE Lunch, unless otherwise instructed. <input type="checkbox"/> Give insulin AFTER Lunch		Insulin is given BEFORE Snack, unless otherwise instructed. <input type="checkbox"/> Give insulin AFTER Snack**		<input type="checkbox"/> Give Snack** BEFORE Gym																			
Hyperglycemia bG > <u> </u> mg/dL		Test ketones if bG > <u> </u> mg/dL and manage as above for DKA: applies to all times (otherwise use space in Other Orders)																							
Insulin is given BEFORE Lunch, unless otherwise instructed. <input type="checkbox"/> Give insulin AFTER Lunch		Insulin is given BEFORE Snack, unless otherwise instructed. <input type="checkbox"/> Give insulin AFTER Snack**		<input type="checkbox"/> For bG > <u> </u> . No Gym <input type="checkbox"/> For bG > <u> </u> . AND at least <u> </u> hours since last insulin, give insulin correction		<input type="checkbox"/> For bG > <u> </u> . No Gym <input type="checkbox"/> For bG > <u> </u> . AND at least <u> </u> hours since last insulin, give insulin correction																			
Carb Coverage Insulin Instructions		<input type="checkbox"/> Carb coverage ONLY <input type="checkbox"/> Carb coverage PLUS Correction Dose when bG > Target bG AND at least <u> </u> hours since last insulin		<input type="checkbox"/> Carb coverage ONLY <input type="checkbox"/> Carb coverage PLUS Correction Dose when bG > Target bG AND at least <u> </u> hours since last insulin		**SNACK Student may carry and self-administer snacks: <input type="checkbox"/> Yes <input type="checkbox"/> No Time of day <u> </u> AM <u> </u> PM Type, Amount _____ <input type="checkbox"/> NO INSULIN TO BE GIVEN AT SNACK TIME																			
INSULIN ORDERS (CHECK ONE)		<input type="checkbox"/> Correction Dose Method (with Carb Coverage or alone) using: <input type="checkbox"/> Insulin Sensitivity Factor or <input type="checkbox"/> Sliding Scale		<input type="checkbox"/> Sliding Scale		<input type="checkbox"/> Fixed Dose (enter time and dose in Other Orders box)		<input type="checkbox"/> No Insulin at School Glucose Monitoring ONLY																	
Name of Insulin:		<input type="checkbox"/> Syringe <input type="checkbox"/> Pen		<input type="checkbox"/> Insulin Pump (Brand):																					
Target bG = <u> </u> mg/dL		Insulin Sensitivity Factor (ISF) 1 unit decreases bG by <u> </u> mg/dL		Insulin to Carbohydrate Ratio (I:C) For LUNCH: 1 unit: per <u> </u> grams carbs For SNACK: 1 unit: per <u> </u> grams carbs		Basal Rate In School <u> </u> units/hour <u> </u> to <u> </u> AM / PM <u> </u> units/hour <u> </u> to <u> </u> AM / PM		Basal Rate for Gym <u> </u> percent for <u> </u> hours <input type="checkbox"/> Disconnect Pump for gym																	
Correction Dose by ISF: $\frac{bG - Target\ bG}{Insulin\ Sensitivity\ Factor} = \dots\ units\ insulin$		Carb Coverage: # grams carb in meal # grams carb in I:C = <u> </u> units insulin		<input type="checkbox"/> Follow Pump recommendation for bolus dose (If not using Pump recommendation, round dose DOWN to nearest 0.1 unit). <input type="checkbox"/> For bG > <u> </u> mg/dL that has not decreased <u> </u> hours after correction, consider pump failure and notify parent. <input type="checkbox"/> For suspected pump failure: DISCONNECT pump; give insulin by syringe or pen.																					
Round DOWN insulin dose to the closest 0.5 unit for syringe/pen or to the nearest whole unit if the syringe/pen doesn't have half-units: unless otherwise instructed by the PCP/endocrinologist.																									
Sliding Scale Do NOT overlap ranges (e.g., enter as 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given.		<input type="checkbox"/> Pre-Lunch <input type="checkbox"/> Pre-Snack <input type="checkbox"/> Correction dose		<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>bG Range mg/dL</th> <th>Insulin</th> </tr> </thead> <tbody> <tr> <td align="center">0</td> <td></td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>		bG Range mg/dL	Insulin	0						<input type="checkbox"/> Other time		<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>bG Range mg/dL</th> <th>Insulin Units</th> </tr> </thead> <tbody> <tr> <td align="center">0</td> <td></td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>		bG Range mg/dL	Insulin Units	0					
bG Range mg/dL	Insulin																								
0																									
bG Range mg/dL	Insulin Units																								
0																									
Home Medications		Dose	Frequency	Time	OTHER ORDERS (such as "Fixed Dose" orders, adjustments for rounding)																				
Insulin:																									
Oral:																									
Health Care Practitioner (Please Print)		LAST NAME			FIRST NAME			Signature	Date <u> </u> / <u> </u> / <u> </u>																
Address		Tel. (____) _____			Fax. (____) _____			CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.																	
NYS License # (Required)		Medicaid#			NPI #																				

Student Last Name	First Name	MI	Date of birth ____/____/____	School
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MONITORING BLOOD SUGAR, MEDICATION AND DIETARY NEEDS:

PARENT/GUARDIAN'S CONSENT 2016-2017

I hereby consent to:

- (1) the monitoring of my child's blood sugar;
- (2) the provision of medically prescribed treatment and/or;
- (3) the treatment of hypoglycemic episodes on school premises or school-sponsored activities, in accordance with the attached instructions of his/her health care practitioner.

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-Ventolin 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 if I provide any medication, it must be supplied in its original and UNOPENED medication box. I understand that I must furnish all necessary snacks, equipment and supplies and that I must immediately advise the school nurse, of any change in the prescription or instructions stated above.

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 regarding the administration of the above-prescribed monitoring and treatment (whichever is earlier).

I recognize that the New York City Department of Health and Mental Hygiene ("DOHMH"), DOE, and their agents have a responsibility to ensure a safe environment in the medical room and anywhere else where my child may test his or her blood sugar. I will make every effort to provide the school with safety lancets and other safer needle devices for the purpose of glucose monitoring and insulin administration.

By submitting this Diabetes Medication Administration Form, I am requesting that my child be provided with specific health services by DOHMH through the Office of School Health ("OSH"). I understand that part of these services may entail a clinical assessment and/or physical examination by an OSH health care practitioner. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this form. I understand that OSH, 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 recognize that this form is not an agreement by OSH or 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 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.

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 ____/____/____
bG monitoring without supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin administration without supervision: <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):	
Revisions per OSH after consultation with prescribing health care practitioner.	

REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

OFFICE OF SCHOOL HEALTH - School Year 2016-2017

ATTACH STUDENT PHOTO HERE	Student Last Name	First Name	Middle	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
				___/___/____ MM DD YYYY	
	Guardian e-mail address*			OSIS Number _____	
School (include name, number, address and borough)			DOE District	Grade	Class
			____	____	____

Health Care Practitioner's Statement/Order

ONE ORDER PER FORM (make copies of this form for additional orders)

(Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization).

- | | | |
|---|--|--|
| <input type="checkbox"/> Clean Intermittent Catheterization Cath. Size _____
<input type="checkbox"/> Central Venous Line
<input type="checkbox"/> Gastrostomy/Jejunostomy Feeding: <input type="checkbox"/> Bolus <input type="checkbox"/> Pump <input type="checkbox"/> Gravity
<input type="checkbox"/> FeedingTube replacement if dislodged - specify in area below
<input type="checkbox"/> Naso-Gastric Feeding
<input type="checkbox"/> Specialized/Non-Standard Feeding
<input type="checkbox"/> Oral / Pharyngeal Suctioning | <input type="checkbox"/> Tracheostomy Care Trach. Size _____
<input type="checkbox"/> Trach. suctioning Cath. Size _____
<input type="checkbox"/> Trach replacement - specify in area below
<input type="checkbox"/> Oxygen Administration
<input type="checkbox"/> Pulse Oximetry monitoring
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Ostomy Care
<input type="checkbox"/> Chest Clapping
<input type="checkbox"/> Percussion
<input type="checkbox"/> Postural Drainage
<input type="checkbox"/> Dressing Change |
|---|--|--|

Student will also require treatment: during transport on school-sponsored trips during afterschool programs

Select the most appropriate option for this student:

- Nurse-Dependent Student: nurse must administer treatment
- Independent Student: student is self-carry/self-administer (**NOT ALLOWED FOR CONTROLLED SUBSTANCES**): PARENT MUST INITIAL REVERSE SIDE
- I attest student demonstrated the ability to self-administer the prescribed treatment effectively for school/field trips/school-sponsored events _____
 Practitioner's initials

1. Diagnosis Enter ICD Codes and Conditions (RELATED TO THE DIAGNOSIS)

□ _____ □ _____

Diagnosis is self-limited Yes No

2. Treatment required in school:

Feeding: _____

Formula Name	Concentration	Route	Amount/Rate	Duration	Frequency/specific time(s) of administration
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Oxygen administration: _____ _____ prn O2 Sat < _____%

Amount (L)	Route	Frequency/specific time(s) of administration	Specify Symptoms
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Other Treatment: _____ _____

prn	Treatment Name	Route	Frequency/specific time(s) of administration	Specify Symptoms
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Additional Instructions or Treatment:

3. Conditions under which treatment should not be provided:

4. Possible side effects/adverse reactions to treatment:

5. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:

6. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:

7. Date(s) when treatment should be: Initiated ___/___/_____ terminated ___/___/_____

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 ___/___/_____	

REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

OFFICE OF SCHOOL HEALTH - School Year 2016-2017

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF ORDERS

PARENT/GUARDIAN'S CONSENT

I hereby consent to the provision of medically prescribed treatment in accordance with the attached instructions of my child's health care practitioner. I understand that it is my responsibility to furnish all necessary equipment and supplies for the provision of the requested treatment, and that I must immediately advise the school nurse of any change in the prescription or instructions stated above.

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 regarding the administration of the above-prescribed monitoring and treatment (whichever is earlier).

By submitting this Request for Provision of Medically Prescribed Treatment (Non-Medication) Form, I am requesting that my child be provided with specific health services by the Department and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH). Full and complete instructions regarding the provision of the above-requested health service(s) are included in this form. I understand that the Department, DOHMH 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 recognize that this form is not an agreement by the Department or DOHMH to provide the services requested, but, rather, my request, consent and authorization 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 the Department or DOHMH, and their employees and agents, may contact, consult, 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 TREATMENT: Initial this paragraph for prescribed treatments self-administered by the student**

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed treatment. I further consent to my child's self-administration of the above-prescribed treatment in school. I acknowledge that I am responsible for providing my child with such equipment in containers labeled as described above, for any and all monitoring of my child's use of such treatment, for any and all consequences of my child's self-treatment in school. I understand that the school nurse will confirm my child's ability to self-treat in a responsible manner. In addition, I agree to provide "back-up" equipment 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 equipment and/or administering treatment to my child in the event that my child is temporarily incapable of self-storage and/or self-treatment.

Parent/Guardian's Signature	Print Parent/Guardian's Name
Date Signed ___/___/_____	Parent/Guardian's Address
Telephone Numbers: Daytime (____) _____ - _____ Home (____) _____ - _____ Cell Phone* (____) _____ - _____	
Alternate Emergency Contact's Name	Alternate Contact's Telephone Number (____) _____ - _____

DO NOT WRITE BELOW – FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

Student Last Name	First Name	MI	OSIS No: _____
Received by: Name	Date ___/___/_____	Reviewed by: Name	Date ___/___/_____
<input type="checkbox"/> 504 <input type="checkbox"/> IEP <input type="checkbox"/> Other	Referred to School 504 Coordinator: <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			
Self-Directs Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Signature and Title (RN OR SMD):		Date School Notified & Form Sent to DOE Liaison ___/___/_____	

FOR Office of School Health (OSH) USE: Revisions as per OSH contact with prescribing health care practitioner.

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

MEDICAL REVIEW FOR 504 ACCOMMODATIONS 2016-2017

Name of Student _____ DOB ____ / ____ / ____ Student ID# _____
 School Name _____ School ATS/DBN: _____ Grade/Class _____

To be completed by the Student's Health Care Practitioner

1. Medical Diagnosis/Disability/ICD-10 Code/DSM-V Code(s): _____

<input type="checkbox"/> AD – Attention Deficit/ Hyperactivity/Conduct	<input type="checkbox"/> CA – Cancer	<input type="checkbox"/> EY – Eye/Vision	<input type="checkbox"/> SK – Skin Disorder
<input type="checkbox"/> AL – Allergy/Food/Medication	<input type="checkbox"/> CV – Cardiovascular/Syncope	<input type="checkbox"/> GI - Gastrointestinal	<input type="checkbox"/> Other
<input type="checkbox"/> AS – Asthma/Airway Disease	<input type="checkbox"/> DI – Diabetes/Glycogen Storage	<input type="checkbox"/> MO – Mobility Impairment	
<input type="checkbox"/> BL – Anemia/Blood Disorder	<input type="checkbox"/> EA – Ear/Hearing	<input type="checkbox"/> NU – Neuro/Epilepsy/Seizures	

2. Is this a temporary condition? Yes No Specify estimated duration of condition: _____ weeks

3. Requested Accommodations: please complete table below.

If request is for a diagnosis of allergies/anaphylaxis, diabetes, or seizure disorder, please also review and complete the applicable section(s) on the back of this form.

Diagnosis/Condition	Accommodation	Expected Duration (weeks)	How does diagnosis affect educational performance? (<i>attach addendum if needed</i>)
1.	<input type="checkbox"/> Air Conditioning <input type="checkbox"/> Ambulation Assistance <input type="checkbox"/> Elevator Pass <input type="checkbox"/> Paraprofessional <input type="checkbox"/> Other: _____		
2.	<input type="checkbox"/> Air Conditioning <input type="checkbox"/> Ambulation Assistance <input type="checkbox"/> Elevator Pass <input type="checkbox"/> Paraprofessional <input type="checkbox"/> Other: _____		
3.	<input type="checkbox"/> Air Conditioning <input type="checkbox"/> Ambulation Assistance <input type="checkbox"/> Elevator Pass <input type="checkbox"/> Paraprofessional <input type="checkbox"/> Other: _____		

*If the requested accommodation is for a paraprofessional, please list the tasks/responsibilities the paraprofessional must perform in order to support the student. **Note:** *paraprofessionals may not give insulin or supervise insulin administration.*

4. Have the appropriate orders (medications and/or procedures) been completed for school treatment? Yes No N/A

If no, please specify/explain:

Health Care Practitioner Information

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

MEDICAL REVIEW FOR 504 ACCOMMODATIONS 2016-2017

To Completed by the Student's Health Care Practitioner

Allergies/Anaphylaxis
(note Available School-Specific Allergy Resources listed below)

List allergen(s): _____

Source of allergy documentation: Skin Testing Blood Test Parental Report
History of Anaphylaxis? Yes No

If yes, specify symptoms: _____
Medications _____

Was an **Allergy/Anaphylaxis MAF** completed? Yes No

Does the student have a history of developmental or cognitive delay? Yes No

If yes, specify diagnosis/diagnoses _____

Does the student have prior experience with self-monitoring? Yes No

- Can the student:
- Independently self-monitor and self-manage?
 - Recognize symptoms of an allergic reaction?
 - Promptly inform an adult as soon as accidental exposure occurs or symptoms appear, or ask a friend for help?
 - Follow safety measures established by a parent/guardian and/or school team?
 - Understand not to trade or share foods with anyone?
 - Understand not to eat any food item that has not come from or been approved by a parent/guardian?
 - Wash hands before and after eating?
 - Develop a relationship with the school nurse or another trusted adult in the school to assist with the successful management of allergy in the school?
 - Carry an epinephrine auto-injector?

Provider Signature _____

Diabetes

When was the student diagnosed with diabetes? / /

Are current DMAF orders on file at school for this student? Yes No

Does the student have any cognitive challenges or physical disabilities that interfere with the student providing self-care for their diabetes? If yes, please specify: Yes No

Can the student identify symptoms of hypoglycemia? Yes No

Can the student notify an adult when they feel that their blood glucose is not normal? Yes No

What is the plan to transition the student to independent functioning? _____

Provider Signature: _____

Seizure Disorder

Type of Seizure _____

Frequency of Seizures _____

Medication(s), including emergency medications _____

Are the seizures well-controlled by the current medication regimen? Yes No

Does the student require routine or prn emergency medication in school? Yes No

If yes, has an MAF been completed? Yes No

Other Associated Symptoms, including medication side effects _____

Number of seizure-related ER visits during the past year _____

Number of seizure-related hospitalizations/ICU admissions _____

Frequency of office visits/monitoring _____ weeks months

Last Office Visit / /

Activity Restrictions _____

Provider Signature _____

School Use Only

Available School-Specific Allergy Resources

- Allergy Table(s) in the lunchroom: _____ staff members for supervision
- Allergy Table(s) in the classroom: _____ staff members for supervision
- General Staff Training for Epinephrine administration: _____ staff members trained
- Student-Specific Training for Epinephrine administration: _____ staff members trained
- Allergy Response Plan
- Other: _____

Name of Principal or Principal's Designee: _____

REQUEST FOR SECTION 504 ACCOMMODATIONS 2016-2017

Name of Student _____ DOB ____ / ____ / ____ Student ID# _____
 School Name _____ School ATS/DBN: _____ Grade/Class _____
 Name of Requesting Parent/Guardian _____ Relationship to Student: _____
 Date Submitted to the 504 Coordinator ____ / ____ / ____ Name of 504 Coordinator _____

PART 1: To be completed by the parent/guardian; submit to the school 504 Coordinator

Describe the concern below and how it affects the student's educational performance:

Indicate accommodations requested based on the concern above. Please consult the school-based 504 Coordinator with any questions.

Request for Educational Accommodation(s) <i>Check all requested:</i>		For school use only	
		Approve	Deny
Testing Accommodations	<input type="checkbox"/> Test schedule/administration time (e.g. extended time, etc.) <input type="checkbox"/> Test setting/location <input type="checkbox"/> Method of presentation/Directions/Assistive Technology <input type="checkbox"/> Method of test response/content support <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Classroom / Curriculum Accommodations	<input type="checkbox"/> Class schedule/use of time <input type="checkbox"/> Class activities setting <input type="checkbox"/> Method of presentation/Directions/Assistive Technology <input type="checkbox"/> Method of class activities response/Content Support <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Academic Supports and Services	<input type="checkbox"/> Health Paraprofessional* <input type="checkbox"/> new request <input type="checkbox"/> renewal request <input type="checkbox"/> Safety Net (<i>high school only</i>) <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other Accommodation (please specify)**		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

* Paraprofessional requests must be reviewed by an Office of School Health Physician in order to determine medical necessity. Additional forms must be completed; please check with your 504 Coordinator.

**Transportation Requests: A Medical Evaluation Request form, available on the DOE website, must be used for specialized transportation accommodations.

Part 2: PARENT CONSENT - To be completed by the student's parent/guardian prior to submitting to School 504 Coordinator

To determine whether your child is eligible for accommodations under Section 504 of The Rehabilitation Act of 1973, a school-based 504 team will convene to review your child's records, including the physician's statement (if applicable), classroom observations and assignments, assessment data, and other information. If your child is eligible to receive accommodations, a 504 Plan will be developed with your input and consent. The 504 Plan may be reviewed at any time, but at a minimum must be reauthorized each school year..

By signing this form, you are giving consent to the 504 team to review your child's records and take the necessary steps to determine whether your child is eligible to receive accommodations. You also acknowledge that you have provided full and complete information to the best of your ability and understand that the Office of School Health (OSH), New York City Department of Education (DOE), their agents, and their employees are relying on the accuracy of the information provided to determine whether and to what extent your child may receive accommodations under Section 504. Additionally, you hereby authorize OSH and DOE and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to your child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to your child.

- Completed HIPAA form attached (**REQUIRED FOR REVIEW; PARENTS MUST COMPLETE THE BACK OF THIS FORM**).

Name of Parent/Guardian _____ Daytime Phone Number _____
 Signature of Parent/Guardian _____ Date _____



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

Medical Record from (insert date) _____ to (insert date) _____

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Other: _____ Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____

Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
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12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
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All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**