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

KONSANTMAN PARAN/RESPONSAB

Nan dokiman sa a, mwen bay otorizasyon pou yo bay pitit mwen an medikaman li ak pou yo mete medikaman an ansanm avèk ekipman nesesè pou ba l medikaman an nan kabinè enfimri lekòl la, dapre rekòmandasyon doktè pitit mwen an. Mwen rekonèt mwen dwe bay lekòl la medikaman an ak ekipman nesesè pou bay li, tankou ponp pou opresyon *non-Ventolin inhalers*. Mwen rekonèt mwen dwe bay medikaman an nan flakon famasi vann li a ak tout etikèt li (mwen dwe mande famasi a yon lòt flakon orijinal pou pitit mwen itilize nan lekòl la); etikèt ki sou medikaman doktè preskri a dwe gen non elèv la, non ak nimewo telefòn famasi a, non doktè ki preskri medikaman an, dat ak kantite fwa yo ka renouvle preskripsyon an, non medikaman an, dòz yo preskri a, kantite fwa pou yo bay timoun lan medikaman an, jan pou yo bay li ak/oswa lòt enstriksyon; yo dwe kite medikaman yo vann san preskripsyon ak echantiyon medikaman nan flakon orijinal fabrikan an yo, avèk non elèv la sou flakon. Mwen konprann mwen dwe remèt tout medikaman nan bwat orijinal yo ki POKO OUVRI. Mwen rekonèt tou mwen dwe avèti enfimyè lekòl la imedyatman si gen nenpòt chanjman nan preskripsyon an oswa nan enstriksyon ki pi wo a.

Mwen rekonèt yo p ap kite okenn elèv ni pote ni pran medikaman ki vann ak preskripsyon.

Mwen konprann MAF sa a valab jis nan fen sesyon pwogram ansèyman pandan ete Depatman edikasyon Vil Nouyòk la; oswa lè mwen bay enfimyè lekòl la nouvo enstriksyon doktè pitit mwen an bay (nenpòt sa ki vin avan an). Depi mwen soumèt MAF sa a, mwen mande pou DOE ak Depatman Sante ak Ijyèn mantal vil Nouyòk New York City Department of Health and Mental Hygiene (DOHMH) bay pitit mwen an sèvis sante espesifik pa entèmedyè Biwo Sante nan lekòl Office of School Health (OSH). Mwen konprann sèvis sa yo ka genyen yon evalyasyon klinik ak yon konsiltasyon fizik yon ajan swen sante OSH ap fè. Nou mete tout enstriksyon konsènan fason pou ofri sèvis sante yo mande pi wo a nan MAF sa a an detay. Mwen konnen OSH ak reprezantan yo, ak anplwaye k ap ede ofri sèvis sante yo mande pi wo a konte sou presizyon enfòmasyon moun bay nan fòm sa a.

Mwen konprann apre dat ekspirasyon MAF la, yon ajan swen sante OSH kapab konsilte pitit mwen an pou evalye sentòm opresyon li an ak kòman medikaman an ap mache pou li. epi li kapab bay yon nouvo MAF. Si ajan sante OSH la wè li pa nesesè pou fè chanjman nan preskripsyon MAF la, li gen dwa bay yon nouvo MAF avèk menm preskripsyon yo k ap ekspire nan yon ane amwenske ajan sante pitit mwen founi yon nouvo MAF. Si ajan sante OSH la wè, dapre yon egzamen medikal ak istwa medikal pitit mwen an, yo dwe chanje preskripsyon MAF la , li gen dwa bay yon nouvo MAF avèk diferan preskripsyon k ap ekspire nan yon ane amwenske ajan sante pitit mwen founi yon nouvo MAF. Y ap mete ni mwenmenm, ni ajan sante ki nan dosye pitit mwen an konnen lè yo fè yon nouvo MAF ak nenpòt chanjman ki gen nan preskripsyon yo. Mwen konprann tou mwen gen jiska 30 jou avan dat ekspirasyon MAF sa a pou mwen soumèt yon nouvo MAF oswa pou mwen fè objeksyon alekri bay enfimyè lekòl la pou yo pa egzamine pitit mwen an. Si mwen pa soumèt yon nouvo MAF bay enfimyè lekòl la, oswa si mwen pa avize enfimyè a alekri pou m di mwen pa vle pou ajan sante OSH egzamine pitit mwen an, nan delè sa a, yo ka egzamine pitit mwen an epi bay yon nouvo MAF.

Mwen rekonèt fòm sa a pa reprezante yon kontra OSH ak DOE pou bay sèvis mwen mande yo, men li reprezante pito demann mwen fè pou sèvis sa yo ak konsantman mwen pou pitit mwen an resevwa sèvis sa yo. Si yo deside sèvis sa yo nesesè, li ka nesesè pou tabli yon plan akomodasyon pou elèv la tou, epi se lekòl la ki pral mete l anplas.

Mwen konprann OSH ak DOE ak anplwaye yo, ak moun ki reprezante yo kapab kontakte, mande avi tout founisè sèvis sante ak/oswa famasyen ki founi pitit mwen an sèvis sante ak/oswa tretman pou jwenn tout lòt enfòmasyon yo ka jije apwopriye osijè eta sante pitit mwen an, medikaman li pran ak/oswa tretman y ap ba li.

****MEDIKAMAN POU TIMOUN LAN PRAN POUKONT LI : Mete inisyal ou akote paragraf sa a pou itilizasyon yon *epinephrine*, ponp medikaman pou opresyon ak lòt medikaman yo apwouve pou timoun lan pran poukont li):**

_____ Mwen sètifye la a yo byen montre pitit mwen an jan pou l pran medikaman yo preskri l la poukont li, epi li ka pran l poukont li. Mwen konsanti tou pou pitit mwen an pote, konsève ak pran medikaman ki preskri pi wo a poukont li nan lekòl la. Mwen rekonèt se responsablite m pou bay pitit mwen an medikaman sa a nan flakon ki gen etikèt jan yo dekri sa pi wo a, pou kontwole jan pitit mwen ititlize medikaman sa a, epitou pou nenpòt konsekans ki rive akoz pitit mwen ap ititlize medikaman sa a nan lekòl la.. Mwen konnen enfimyè lekòl la ap konfime kapasite pitit mwen an pou pote ak pou pran medikaman an poukont li yon fason responsab. Anplis, mwen dakò pou bay lekòl la "lòt flakon" medikaman ki gen etikèt kote yo ekri aklè non medikaman an pou konsève nan enfimri lekòl la si pitit mwen an pa ta rete ase nan medikaman li pote pou pran poukont li.

____ Mwen bay konsantman m pou enfimyè lekòl la pou kenbe nan lekòl la ak/oswa bay pitit mwen an medikaman sa a nan ka kote pitit mwen an pa ta kapab kenbe oswa pran medikaman sa pou kont li pou yon ti bout tan.

_____**Mwen sètifye, nan dokiman sa a, mwen pale avèk ajan swen sante pitit mwen an, epi mwen bay konsantman m pou biwo sante nan lekòl la ba pitit mwen an medikaman opresyon ki disponib nan lekòl la nan ka kote medikaman opresyon yo preskri pitit mwen an pa ta disponib.**

*Ou dwe voye pitit ou a avèk yon **Personal Metered Dose Inhaler (MDI)** lè li prale nan **jounen pwomnad lekòl** la pou li ka disponib si l bezwen li. Yo ka itilize medikaman opresyon lekòl la genyen an **sèlman** lè pitit ou a nan bilding lekòl la.*

Siyati Paran/Responsab	**Ekri ak lèt detache Non Paran/Responsab**
Dat ou siyen fòm lan __ __ / __ __ / __ __ __ __	**Adrès Paran/Responsab**
Nimewo telefòn: Lajounen (__ __ __) __ __ __ - __ __ __ __ Lakay (__ __ __) __ __ __ - __ __ __ __ **Selilè*** (__ __ __) __ __ __ - __ __ __ __	
Adrès imèl Paran/Responsab*	
Lòt non moun nou ka kontakte lè gen yon ijans	**Nimewo Telefòn lòt moun pou nou kontakte a** (__ __ __) __ __ __ - __ __ __ __

PA EKRI PI BA A - PLAS SA A REZÈVE POU BIWO OSH SÈLMAN (DO NOT WRITE BELOW – FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY)

Received by: Name Date __/__/____	**Reviewed by**: Name Date __/__/____
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):	

Confidential information should not be sent by e-mail.

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ATTACH STUDENT PHOTO HERE	**Student** Last Name First Name Middle	**Date of birth** __ __ / __ __/ __ __ __ __ M M D D Y Y Y Y	☐ Male ☐ Female
		OSIS # __ __ __ __ __ __ __ __ __	
	School (include name, number, address and borough	**DOE District** __ __	**Grade** / **Class**

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

Diagnosis	**Select Asthma Severity and Control**				
□ Asthma	**Severity:**	□ Intermittent	□ Mild Persistent	□ Moderate Persistent	□ Severe Persistent
Other:	**Control:**	□ Well-controlled	□ 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	□ Y	□ N	□ U	History of asthma-related:			
History of life-threatening asthma (e.g., with loss of consciousness or with hypoxic seizure)	□ Y	□ N	□ U	PICU admissions (ever)	□ Y	□ N	□ U
Received oral steroids within past 12 months: ___ times	□ Y	□ N	□ U	ER visits within past 12 months: __ times	□ Y	□ N	□ U
Date last oral steroids received: __ __ /__ __ /__ __				Hospitalizations within past 12 months: __ times	□ Y	□ N	□ U
History of food allergy, eczema, specify _____	□ Y	□ N	□ U				

Select In School ASTHMA Medications	**In School Instructions**
1. Quick Relief Medications Choose **ONLY** one: ☐ **Albuterol** *[Ventolin® can be provided by school for shared usage (plus individual spacer): **see back**].* ☐ MDI with spacer ☐ DPI ☐ **Other Medication Order:** Name: _____ Dose: _____ Route: _____Time interval: q __hrs **Instructions:**	☐ **Standard Order:** Give **2 inhalations** 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** **OR** **If in Respiratory distress***: call 911 and give **6 inhalations**; then may repeat 6 inhalations q 20 minutes until EMS arrives. ☐ **Pre-exercise:** give **2 inhalations** 15 -20 minutes before exercise. ☐ **URI symptoms or recent asthma flare (within 5 days):** give **2 inhalations** @ noon for 5 days.
2. Controller Medications for In-School Administration ***(Recommended for Persistent Asthma, per NAEPP Guidelines)*** SPECIFY **Name(s)** of medication ☐ **Inhaled corticosteroid (ICS)**:_____ Strength _____ ☐ MDI with spacer ☐ DPI ☐ **Other:** _____ Strength _____ Dose: _____Route: _____ Time interval: q _____	☐ **Standing daily dose**: ___ inhalations *once a day* at ____ AM OR ____ PM **OR** ___ inhalations *twice a day* at ____ AM and ____ PM Special Instructions:

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. ☐ 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. (__ __ __) __ __ __ - __ __ __ __	**CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.**
NYS License # **(Required)** _____	Medicaid# __ __ __ __ __ __ __ __	NPI # __ __ __ __ __ __ __ __ __ __	

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