

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藥的次數、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，都必須是在一個原裝和未曾開封的藥物盒裏的。我也理解，如果上述處方或說明發生任何變化，則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限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為止，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為止（以這兩者中較早的時間為準）。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了此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，這一表格並不是學校健康辦公室和教育局同意提供所申請服務的同意函，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提供，則一份「學生照顧計劃」（Student Accommodation Plan）可能也是有必要的，將由學校填寫。

我理解，學校健康辦公室和教育局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為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處方epinephrine可使用時施用儲存的epinephrine。

在您子女參加學校外出參觀的日子以及/或者課後計劃，您必須讓子女隨身帶上epinephrine、其個人定量吸入器（MDI）以及其他任何獲准的自我施用藥物，以備您子女使用。儲存的epinephrine僅供您子女在學校教學樓內使用。

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* (____) _____ - _____	
家長/監護人電子郵箱*	
其他緊急聯絡人姓名	聯絡電話 (____) _____ - _____
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):	

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