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

KONSANTMAN PARAN/RESPONSAB

Nan dokiman sa a, mwen bay konsantman mwen pou yo founi pitit mwen an tretman medikal ajan sante pitit mwen an rekòmande nan preskripsyon mwen voye ak dokiman sa a. Mwen konprann se responsablite pa m pou mwen founi tout ekipman ak materyèl ki nesesè pou yo bay tretman mwen mande a, epi mwen sipoze mete enfimyè lekòl la okouran imedyatman tout chanjman nan preskripsyon oswa enstriksyon ki pi wo a.

Mwen konprann konsantman sa a valab jis nan fen sesyon pwogram ansèyman pandan ete Depatman edikasyon Vil Nouyòk patwone a sèlman; oswa lè mwen bay enfimyè lekòl la yon nouvo preskripsyon oswa enstriksyon ajan sante pitit mwen an bay osijè kòman pou yo fè siveyans ak tretman pi wo a (nenpòt sa ki vin avan an).

Lè mwen soumèt Fòm sa a pou mande bay pitit mwen an tretman medikal yo rekòmande yo (se pa medikaman), mwen mande pou Depatman Sante ak Ijyèn mantal Vil Nouyòk *New York City Department of Health and Mental Hygiene* (NYCDOHMH) pa lentèmedyè Biwo Sante nan lekòl *Office of School Health* (OSH) ofri pitit mwen sèvis espesifik sante. Nou mete tout enstriksyon konsènan fason pou ofri sèvis sante yo mande pi wo a nan Fòm sa a. Mwen konnen ke Depatman an, DOHMH 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 rekonèt fòm sa a pa reprezante yon kontra ak Depatman an oswa DOHMH pou bay sèvis mwen mande yo, men li reprezante pito demann mwen fè, konsantman ak otorizasyon mwen bay pou 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 Depatman an ak DOHMH 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.

****TRETMAN POU TIMOUN LAN FÈ POUKONT LI : Mete inisyal ou bò kote paragraf sa a pou tretman elèv la ap fè poukont li**

_____ Mwen sètifye la a yo byen montre pitit mwen an jan pou l fè tretman yo preskri l la poukont li. Mwen konsanti tou pou pitit mwen an pran medikaman ki preskri pi wo a poukont li nan lekòl la. Mwen rekonèt se responsablite pa m pou bay pitit mwen an ekipman sa a nan flakon ki gen etikèt jan yo dekri sa pi wo a, pou kontwole jan pitit mwen ititlize tretman sa a, epitou pou nenpòt konsekans ki rive akoz pitit mwen ap fè tretman sa a poukont li nan lekòl la. Mwen konnen enfimyè lekòl la ap konfime kapasite pitit mwen an pou fè tretman an poukont li yon fason responsab. Anplis, mwen dakò pou bay lekòl la "lòt flakon" ekipman 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 ekipman ak/oswa bay pitit mwen atretman sa a nan ka kote pitit mwen an pa ta kapab kenbe ekipman an oswa fè tretman an pou kont li pou yon ti bout tan.

Siyati Paran/Responsab	**Ekri ak lèt detache Non Paran/Responsab**
Dat ou siyen fòm lan __ __ / __ __ / __ __ __ __	**Adrès Paran/Responsab**
Nimewo telefòn: Lajounen (__ __ __) __ __ __ - __ __ __ __ Lakay (__ __ __) __ __ __ - __ __ __ __ **Selilè*** (__ __ __) __ __ __ - __ __ __ __	
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)	
Student Last Name First Name MI	OSIS No: __ __ __ __ __ __ __ __
Reviewed by: Name Date __ __ / __ __ / __ __ __ __	
☐ **504** ☐ **IEP** ☐ **Other**	**Referred to School 504 Coordinator**: ☐ Yes ☐ No
Services provided by: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center	
Self-Directs Treatment: ☐ Yes ☐ No	
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.

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OFFICE OF SCHOOL HEALTH - School Year 2016-2017

ATTACH STUDENT PHOTO HERE	**Student** Last Name First Name Middle	**Date of birth** __/__/____ MM DD YYYY	☐ Male ☐ Female
	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 from for additional orders)
(Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization).

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

Oxygen administration: _____ _____ ☐ _____ ☐ prn ☐ O2 Sat < _____% ☐ _____
Amount (L) / Route / Frequency/specific time(s) of administration / Specify Symptoms

Other Treatment: _____ _____ ☐_____ ☐ prn_____
Treatment Name / Route / Frequency/specific time(s) of administration / Specify Symptoms

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 __/__/____

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

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