

**Parent must complete and SIGN reverse side of this Medication Form and submit to nurse along with a current photograph attached to upper left corner.**

<b>MEDICATION ADMINISTRATION FORM</b> <b>Authorization for Administration of Medication to Students for School Year 2009–2010</b>	Student's Name ( <i>Last, First, Middle</i> )		Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth	I.D. Number
	DOE Region/District	School (PS, IS, etc. and Name)		Grade	Class
	School Address				Zip Code

<b>Physician's Order</b>	<b>Check Medication and Order Type</b>	<b>Instructions for lack of improvement or adverse reaction</b>	<b>Choose all that are appropriate</b>
<p><b>1. Diagnosis</b>    <b>ASTHMA</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>SEVERITY:</b></p> <p><input type="checkbox"/> Intermittent                      <input type="checkbox"/> Moderate Persistent*</p> <p><input type="checkbox"/> Mild Persistent*                      <input type="checkbox"/> Severe Persistent*</p> <p><input type="checkbox"/> Exercise Induced</p> <p>*National guidelines recommend inhaled corticosteroids for children with persistent asthma.</p> <p><b>INDICATE HOME MEDS IN BOTTOM LEFT BOX.</b></p>	<p><i>Stock supply only available for Ventolin HFA. (see back)</i></p> <p><input type="checkbox"/> Ventolin HFA (may be provided by school for shared usage).</p> <p><input type="checkbox"/> Other HFA _____ (to be provided by parent).</p> <p style="text-align: center;"><b>ORDER TYPE</b></p> <p><input type="checkbox"/> <b>Standard order.</b> 2 puffs q 4 hrs. via MDI and spacer prn cough, wheeze, tightness in chest, difficulty breathing or shortness of breath. May repeat in 15 mins x 2 if no improvement (3 total).</p> <p><input type="checkbox"/> <b>Pre exercise.</b> 2 puffs via MDI with spacer 15-30 minutes before exercise.</p> <p><input type="checkbox"/> <b>URI or recent asthma flare</b> (within 3 days). 2 puffs @ noon via MDI inhaler and spacer for 3-5 days.</p>	<p>If improved, but not enough to return to class, call parent. If significant respiratory distress persists, call 911 and notify parent and PMD. May provide additional puffs as needed until EMS arrives.</p>	<p><input type="checkbox"/> Student may carry medication and may self-administer. <b>(PARENT MUST INITIAL REVERSE SIDE.)</b></p> <p><input type="checkbox"/> Store medication in medical room and student to self-administer under observation.</p> <p><input type="checkbox"/> Store medication in medical room and nurse to administer.</p>

<p><b>2. Diagnosis</b> _____</p> <p>_____</p> <p>Medication/Preparation/Concentration</p> <p>_____</p> <p>Dose/Route</p> <p><input type="checkbox"/> Diagnosis substantially controlled with medication.</p> <p><input type="checkbox"/> Diagnosis not substantially controlled with medication.</p>	<p><input type="checkbox"/> Standing daily dose. Specify time(s): _____</p> <p>----- <b>AND/OR</b> -----</p> <p><input type="checkbox"/> prn _____</p> <p style="text-align: center;"><i>specific signs, symptoms or situations</i></p> <p>Time interval: q ____ hours as needed</p> <p>Any repeats if no improvement? <input type="checkbox"/> Yes, in ____ hr/mins, max ____ times</p>	<p>Conditions under which medication should not be given:</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Student may carry medication (includes epi pen and MDI) and may self-administer. <b>(PARENT MUST INITIAL REVERSE SIDE.)</b></p> <p>NOT FOR CONTROLLED SUBSTANCES.</p> <p><input type="checkbox"/> Store medication in medical room and student to self-administer under observation.</p> <p><input type="checkbox"/> Store medication in medical room and nurse to administer.</p>
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<p><b>3. Diagnosis</b> _____</p> <p>_____</p> <p>Medication/Preparation/Concentration</p> <p>_____</p> <p>Dose/Route</p> <p><input type="checkbox"/> Diagnosis substantially controlled with medication.</p> <p><input type="checkbox"/> Diagnosis not substantially controlled with medication.</p>	<p><input type="checkbox"/> Standing daily dose. Specify time(s): _____</p> <p>----- <b>AND/OR</b> -----</p> <p><input type="checkbox"/> prn _____</p> <p style="text-align: center;"><i>specific signs, symptoms or situations</i></p> <p>Time interval: q ____ hours as needed</p> <p>Any repeats if no improvement? <input type="checkbox"/> Yes, in ____ hr/mins, max ____ times</p>	<p>Conditions under which medication should not be given:</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Student may carry medication (includes epi pen and MDI) and may self-administer. <b>(PARENT MUST INITIAL REVERSE SIDE.)</b></p> <p>NOT FOR CONTROLLED SUBSTANCES.</p> <p><input type="checkbox"/> Store medication in medical room and student to self-administer under observation.</p> <p><input type="checkbox"/> Store medication in medical room and nurse to administer.</p>
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<b>List medication(s) student takes at home and at what time:</b>	Health Care Practitioner (HCP) Name (PLEASE PRINT)		HCP Signature		<b>FOR DOHMH USE:</b> Revisions per DOHMH after consultation with prescribing provider
	HCP/Clinic Address				
	HCP/Clinic Tel. No.	HCP/Clinic Fax No.	NYS Registration No. (Required)	Date	

**INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS**

