

2009-2010 학년도
의학적으로 처방된 치료 규정 (약품 외) 요청

학생의 성명: 성: _____ 이름: _____ 중간이름: _____
 남: _____ 여: _____ 생년월일(월/일/년): _____ 아이디 번호: _____
 보로: _____ 학군: _____ 학교: _____ 학년: _____ 학급: _____
 학교 주소: _____ 우편번호: _____

Part I: Physician's Statement/Order

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

**Clean Intermittent Catheterization
 Central Venous Line
 Gastrostomy Feeding
 Naso-Gastric Feeding**

**Tracheostomy Care
 Oral/Pharyngeal Suctioning
 Oxygen Administration
 Ostomy Care**

**Chest Clapping
 Percussion
 Postural Drainage
 Dressing Change**

Other _____

1. Diagnosis _____
2. Treatment required in school _____
3. Specific instructions for providing treatment _____
4. Frequency/time to be provided _____
5. Conditions under which treatment should not be provided _____
6. Date(s) when treatment should be initiated _____ terminated _____
7. Possible side effects/adverse reactions to treatment _____
8. Specific instructions for non-medical school personnel in case of adverse reactions _____
9. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions _____
10. Diagnosis is substantially controlled with provision of medically prescribed treatment Yes _____ No _____
11. Diagnosis is self- limited Yes _____ No _____

Physician's Name (Print) _____

Physician's Signature _____

Physician/Clinic's Address _____

NYS Registration No. _____

Date Signed _____

Zip Code _____

Physician/Clinic's Telephone No. _____

Physician/Clinic's Fax No. _____

뉴욕시 교육청 작성 부 FOR DOE/DOHMH USE: Revisions as per DOE/ DOHMH contact with prescribing physician
