Department of Education
Carmen Fariña, Chancellor

Medical Forms Packet

2015-2016

للحصول على ترجمات لهذه الوثائق، يرجى زيارة الموقع الالكتروني المدرج أدناه.	Pour obtenir la traduction de ces documents, merci de visiter le site internet cité ci-dessous.	Переводы документов на русский язык находятся на нижеуказанном сайте.
এসব নথির অনুবাদ পেতে হলে অনুগ্রহ করে নিচে উল্লিখিত ইন্টারনেট সাইটে দেখুন।	Pou ka jwenn kopi dokiman sa yo an Kreyòl Ayisyen, ale sou sit entènèt ki pi ba a	Para obtener una versión de estos documentos en español, por favor visite el sitio de Internet a continuación.
如要取得文件的中文翻譯，請瀏覽下面的網站。	이들 문서의 번역본을 원하시면, 아래 기재된 인터넷 사이트를 방문하십시오.	ان دستاویزات کے ترجمہ کو حاصل کرنے کے لیے، برائے مہربانی ذیل میں درج انٹرنیٹ ویب سائٹ پر جائیں:

http://schools.nyc.gov/Offices/Health/SchoolHealthForms

Department of Education

GUIDELINES FOR THE PROVISION OF HEALTH SERVICES AND/OR SECTION 504 ACCOMMODATIONS FOR STUDENTS IN NEW YORK CITY PUBLIC SCHOOLS - SCHOOL YEAR 2015-2016

To All Parents, Physicians, and Health Care Providers:

The New York City Department of Education and the New York City Department of Health and Mental Hygiene's Office of School Health work collaboratively to make certain that all students with special needs are provided services to ensure their full participation in the educational setting. To this end, parents and providers must use the enclosed forms to request in school direct health services and/or accommodations under Section 504 of the Rehabilitation Act of 1973. **These forms must be returned to the child's school for processing.** A new request and authorization form will be required for each school year if the child continues to require the requested services in school. The following guidelines should be followed in order to facilitate the review of the completed forms and to provide clinically appropriate services:

- The physician/health care provider completing the form should be the one who will actively manage the condition for which services are requested.
- A valid New York State, New Jersey or Connecticut license, Medicaid & NPI number must be provided. If a physician-in-training without a license number completes the form, it must be counter-signed by a supervisor (e.g., attending physician) and include the supervisor's license number.
- The order should be specific, legible and clearly written so that it is completely understandable to the nurse and can be carried out in a clinically responsible way.
- Only those services that must be performed during school hours should be requested, (e.g., if medication can be given at home before or after school hours, it should not be requested in school).
- Homeopathic medications will not be administered.
- Please note that medication is typically stored in a locked cabinet in a designated room (i.e., medical room) unless the student is authorized by you to carry medication in school. In addition, Epinephrine may be stored in the classroom and transported with students according to the Allergy Response Plan.
- Parents, physicians, school staff and students must work together to encourage each child to be as self-sufficient as possible. If the child is able to self-administer the medication, the parent should initial the appropriate area on the back of the medication form. Most students at the intermediate and high school level should be self-directed in taking medications, (i.e., identify the following: that the medication is the correct one; what the medication is for; that the correct dosage or amount is being administered; when the medication is needed during the school day; describe what will happen if it is not taken). Those students are then permitted to carry and self-administer only those medications that are necessary during the school day without supervision; however, **students are never permitted to carry controlled substances.**

Parents, remember to attach a small current photograph of your child to the upper left corner of the Medication Administration Form (MAF) for proper identification.

There are four types of request and authorization forms:

- Medication Administration Forms (MAFs) - should be completed only for requests involving administration of medication for students. For cases of asthma, providers may attach an Asthma Action Plan with the MAF. Use of nebulizers on school trips can be cumbersome, please consider prescribing inhaler and spacer whenever possible. **Please note that there are three separate MAFs: one for asthma medications, one for allergies/anaphylaxis medications, and one for other medications.**

- Provision of Medically Prescribed Treatment (Non-Medication) - should be completed when requesting special procedures such as bladder catheterization, postural drainage, tracheal suctioning, gastrostomy tube feeding, etc. This form may be used for all skilled nursing treatments.

- Diabetes Medication Administration Form - should be completed for students with Diabetes who require any of the following: glucose monitoring, insulin and/or glucagon administration.

- Request for Section 504 Accommodation(s) - should be used when requesting special services such as a barrier-free building, elevator use, testing modification, etc. This form should **NOT** be used for Related Services such as occupational therapy, physical therapy, speech and language therapy, counseling, etc. which is properly addressed and provided by a student's Individualized Education Program (IEP).

Please contact the student's school if you have any questions. Thank you for your assistance.

NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY
MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH
Authorization for Administration of Medication to Students for School Year 2015–2016

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 to be completed by Student's HEALTH CARE PROVIDER

1. Diagnosis:

Medication: : _____
Preparation/Concentration: _____
Dose: _____ Route: _____

Choose all options that are appropriate:
- ☐ Student may carry medication & may self-administer (PARENT MUST INITIAL REVERSE SIDE) CONTROLLED SUBSTANCES NOT ALLOWED.
- ☐ Store medication in medical room & student to self-administer with supervision (PARENT MUST INITIAL REVERSE SIDE).
- ☐ Store medication in medical room and nurse to administer.

Student to carry & self-administer on school trips and/or after-school programs: ☐ Yes (PARENT MUST INITIAL REVERSE SIDE) ☐ No

In School Instructions
☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM
AND/OR
☐ PRN
_____
specify signs, symptoms, or situations
☐ Time interval: q _ _ minutes or q _ _ hours as needed.
☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

2. Diagnosis:

Medication: : _____
Preparation/Concentration: _____
Dose: _____ Route: _____

Choose all options that are appropriate:
- ☐ Student may carry medication & may self-administer (PARENT MUST INITIAL REVERSE SIDE) CONTROLLED SUBSTANCES NOT ALLOWED.
- ☐ Store medication in medical room & student to self-administer with supervision (PARENT MUST INITIAL REVERSE SIDE).
- ☐ Store medication in medical room and nurse to administer.

Student to carry & self-administer on school trips and/or after-school programs: ☐ Yes (PARENT MUST INITIAL REVERSE SIDE) ☐ No

In School Instructions
☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM
AND/OR
☐ PRN
_____
specify signs, symptoms, or situations
☐ Time interval: q _ _ minutes or q _ _ hours as needed.
☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

3. Diagnosis:

Medication: : _____
Preparation/Concentration: _____
Dose: _____ Route: _____

Choose all options that are appropriate:
- ☐ Student may carry medication & may self-administer (PARENT MUST INITIAL REVERSE SIDE) CONTROLLED SUBSTANCES NOT ALLOWED.
- ☐ Store medication in medical room & student to self-administer with supervision (PARENT MUST INITIAL REVERSE SIDE).
- ☐ Store medication in medical room and nurse to administer.

Student to carry & self-administer on school trips and/or after-school programs: ☐ Yes (PARENT MUST INITIAL REVERSE SIDE) ☐ No

In School Instructions
☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM
AND/OR
☐ PRN
_____
specify signs, symptoms, or situations
☐ Time interval: q _ _ minutes or q _ _ hours as needed.
☐ If no improvement, repeat in _ _ minutes or _ _hours for a maximum of __ times.

Conditions under which medication should not be given:

HOME Medications (include over-the counter)	For DOHMH Only
	Revisions per DOHMH after consultation with prescribing provider. ☐ IEP

Health Care Practitioner LAST NAME / FIRST NAME (Please Print)	Signature	
Address	Tel. (___)___-____	Fax. (___)___-____
E-mail address*	Cell* (___)___-____	
NYS License # (Required) __ __ __ __ __ __ / Medicaid # __ __ __ __ __ __ __	NPI #. __ __ __ __ __ __ __ __ __ __	Date __/__/____

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

*Confidential information should not be sent by e-mail

NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY
MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH
Authorization for Administration of Medication to Students for School Year 2015–2016

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __	School

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the school nurse and the principal and/or his/her designee(s) of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this Authorization is only valid until the earlier of: (1) June 30, 2016 (This prescription may be extended through August if the student is attending a New York City Department of Education ("DOE") sponsored summer instruction program); or (2) such time that I deliver to the school nurse and the principal and/or his/her designee(s) a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed medication. By submitting this MAF, I am requesting that my child be provided with specific health services by DOE and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH"). I understand that part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this MAF. I further understand that the OSH, DOE and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize OSH and DOE and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

**SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications):

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize OSH and DOE, their agents and employees; including the school nurse, principal, his/her designee(s), and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

_____ I also authorize the school nurse, the principal, and/or his/her designee(s) to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ I hereby certify that I have consulted with my child's health care provider and that I authorize the Office of School Health to administer stock Ventolin in the event that my child's asthma prescription medication is unavailable.

You must send your child's Personal Metered Dose Inhaler (MDI) with your child on a school trip day in order that he/she has it available.
The stock Ventolin is only for use while your child is in the school building.

Parent/Guardian's Signature	Print Parent/Guardian's Name
Date Signed __ __ / __ __ / __ __ __ __	Parent/Guardian's Address
Telephone Numbers: Daytime (__ __ __) __ __ __ - __ __ __ __ Home (__ __ __) __ __ __ - __ __ __ __ Cell Phone* (__ __ __) __ __ __ - __ __ __ __	
Parent/Guardian e-mail address*	
Alternate Emergency Contact's Name	Contact Telephone Number (__ __ __) __ __ __ - __ __ __ __
DO NOT WRITE BELOW – FOR DOE AND DOHMH ONLY	
Received by: Name Date __/__/____	Reviewed by: Name Date __/__/____
Self-Administers/Self-Carries: ☐ Yes ☐ No	Services provided by: ☐ Nurse ☐ DOHMH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff
Signature and Title (RN OR MD):	

*Confidential information should not be sent by e-mail

ASTHMA

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2015–2016

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 section to be completed by Student's **HEALTH CARE PROVIDER**

Diagnosis	**Select Asthma Severity and Control**
□ Asthma	**Severity:** □ Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent
Other:	**Control:** □ Well-controlled □ Not Controlled □ Poorly Controlled

Student Asthma Risk Assessment Questionnaire (Y = Yes; N = No; U = Unknown)

History of near-death asthma requiring mechanical ventilation □ Y □ N □ U
History of life-threatening asthma (e.g. with loss of consciousness or with hypoxic seizure) □ Y □ N □ U
Received oral steroids within past 12 months: ___times □ Y □ N □ U
Date last oral steroids received: __ __ /__ __ /__ __
History of food allergy, eczema, specify_____ □ Y □ N □ U

History of asthma-related:
PICU admissions (ever) □ Y □ N □ U
ER visits within past 12 months: ____times □ Y □ N □ U
Hospitalizations within past 12 months: ____times □ Y □ N □ U

Select In School ASTHMA Medications	**In School Instructions**

1. Rescue Medications

Stock supply only available for Ventolin® (see back)

Choose **ONLY** one:

☐ Ventolin® provided by school for shared usage (plus individual spacer).
☐ Albuterol (with spacer, to be provided by parent).
- □ May substitute stock Ventolin® **

☐ _____ (with spacer, to be provided by parent).
- □ May substitute stock Ventolin® **

Other:

_____ _____ _____ _____
Name Dose Route Frequency

Instructions:

☐ **Standard order**:
Q4 hrs PRN for coughing, wheezing, tightness in chest, difficulty breathing or shortness of breath (ASTHMA FLARE SYMPTOMS). **Follow instructions below:**
- Administer **2 puffs;** may repeat in 20 minutes **ONCE**
- If no improvement, call EMS and give **6 puffs** every 20 minutes until EMS arrives

☐ **Pre-exercise:** Give **2 puffs**15 -20 minutes before exercise.
☐ **URI symptoms or recent asthma flare: (within 3-5 days):**
- Administer **2 puffs**@ noon for 5 days.

2. Controller Medications for In-School Administration
(Recommended for Persistent Asthma, per NAEPP Guidelines)

Choose **ONLY** one and specify name of medication:

☐ Inhaled corticosteroid (ICS) : _____® with spacer
☐ ICS combined with long-acting beta agonist:_____® with spacer

☐ **Standing daily dose**:
___ puffs *once a day* at ____ AM OR ____ PM
OR ___ puffs *twice a day* at ____ AM and ____ PM
Special Instructions:

Choose all options that are appropriate:

☐ **Student** may carry medication & may self-administer**. ****
☐ Store medication in medical room & **student** to self-administer with supervision**
☐ Store medication in medical room and **nurse** to administer.
Student to self-administer** personal MDI on school trips and/or after-school programs. ☐ Yes ☐ No
Has the student demonstrated the proper technique for MDI self-administration? ☐ Yes ☐ No

****PARENTS MUST INITIAL REVERSE SIDE**

HOME Medications (include over-the counter)	**For DOHMH Only**
	Revisions per DOHMH after consultation with prescribing provider. ☐ IEP

Health Care Practitioner LAST NAME (Please Print)	FIRST NAME	Signature		**The CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.**
Address		Tel. (___)___-____	Fax. (___)___-____	
E-mail address*		Cell* (___)___-____		
NYS License # **(Required)** _____	Medicaid# __ __ __ __ __ __ __	NPI # __ __ __ __ __ __ __ __ __ __	Date __ __/__ __/__ __ __ __	

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

Confidential information should not be sent by e-mail.

ASTHMA

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2015–2016

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __	School

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

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I understand that no student will be allowed to carry or self-administer controlled substances.

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I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize OSH and DOE and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

****SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications):**

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize OSH and DOE, their agents and employees; including the school nurse, principal, his/her designee(s), and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

_____ I also authorize the school nurse, the principal, and/or his/her designee(s) to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ **I hereby certify that I have consulted with my child's health care provider and that I authorize the Office of School Health to administer stock Ventolin in the event that my child's asthma prescription medication is unavailable.**

*You must send your child's **Personal Metered Dose Inhaler (MDI)** with your child on a **school trip day** in order that he/she has it available.*
*The stock Ventolin is **only** for use while your child is in the school building.*

Parent/Guardian's Signature	**Print Parent/Guardian's Name**
Date Signed __ __ / __ __ / __ __ __ __	**Parent/Guardian's Address**
Telephone Numbers: **Daytime** (__ __ __) __ __ __ - __ __ __ __ **Home** (__ __ __) __ __ __ - __ __ __ __ **Cell Phone*** (__ __ __) __ __ __ - __ __ __ __	
Parent/Guardian e-mail address*	
Alternate Emergency Contact's Name	**Contact Telephone Number** (__ __ __) __ __ __ - __ __ __ __
DO NOT WRITE BELOW – FOR DOE AND DOHMH ONLY	
Received by: Name Date __ __/__ __/__ __ __ __	**Reviewed by**: Name Date __ __/__ __/__ __ __ __
Self-Administers/Self-Carries: ☐ Yes ☐ No	**Services provided by**: ☐ Nurse ☐ DOHMH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff
Signature and Title (RN OR MD):	

ALLERGIES / ANAPHYLAXIS

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2015–2016

1`ATTACH STUDENT PHOTO HERE	Student Last Name	First Name	Middle	Date of birth ___/___/____ MM DD YYYY	Weight (kg) ___.__	☐ Male ☐ Female
				OSIS # _ _ _ _ _ _ _ _ _		
	School (include name, number, address and borough)			DOE District ___	Grade	Class

The following section to be completed by Student's HEALTH CARE PROVIDER

Specify Allergy	Specify Allergy	Specify Allergy
☐ Allergy to	☐ Allergy to	☐ Allergy to

History of asthma?	☐ Yes (*If yes, student has an increased risk for a severe reaction)*					☐ No	Does this student have the ability to:
History of anaphylaxis?	☐ Yes Date ___/___/____					☐ No	Self-Manage ☐ Yes ☐ No
If yes, symptoms	☐ Respiratory	☐ Skin	☐ GI	☐ Cardiovascular	☐ Neurologic		Recognize signs of allergic reactions ☐ Yes ☐ No
Treatment	Date ___/___/____						Recognize/avoid allergens independently ☐ Yes ☐ No
History of skin testing?	☐ Yes (attach copy of results) Date ___/___/____					☐ No	Comments:

Select In School Medications

1. ONLY SINGLE DOSE AUTO-INJECTORS SELECT BELOW
   - ☐ Epinephrine Auto-Injector 0.15 mg/0.3 ml
   - ☐ Epinephrine Auto-Injector 0.3 mg/0.3 ml
   - ☐ Give antihistamine in addition to epinephrine (must order antihistamine below)

   Choose all options that are appropriate:
   - ☐ Student may carry medication and may self-administer (INCLUDES SCHOOL TRIPS &/OR AFTER-SCHOOL PROGRAMS) (PARENT MUST INITIAL REVERSE SIDE)
   - ☐ Medication should be kept in close proximity to student; choose option:
     - ☐ Student to self-administer (PARENT MUST INITIAL REVERSE SIDE).
     - ☐ Nurse or trained staff to administer

In School Instructions

PRN (check all that apply):

☐ Itching	☐ Shortness of Breath	☐ Vomiting / Diarrhea
☐ Hives	☐ Tightness / Closure	☐ Weak Pulse
☐ Swelling	☐ Hoarseness	☐ Pallor / Cyanosis
☐ Redness	☐ Wheezing	☐ Dizziness / Fainting

Specify signs, symptoms, or situations:

- Administer Intramuscularly into anterolateral aspect of thigh
- Call 911 immediately

If no improvement, repeat in ___ minutes for a maximum of __ times (not to exceed a total of 3 doses).

2. ORAL MEDICATION: ☐ **Diphenhydramine**

Preparation/Concentration: _____

Route: _____

Choose all options that are appropriate:
- ☐ Student may carry medication and may self-administer (INCLUDES SCHOOL TRIPS &/OR AFTER-SCHOOL PROGRAMS) (PARENT MUST INITIAL REVERSE SIDE)
- ☐ Medication should be kept in close proximity to student; choose option:
  - ☐ Student to self-administer (PARENT MUST INITIAL REVERSE SIDE).
  - ☐ Nurse to administer

PRN (check all that apply):

☐ Itchy / Runny Nose	☐ Itchy Mouth	☐ Few Hives
☐ Sneezing	☐ Mildly Itchy Skin	☐ Mild Nausea / Discomfort

Specify signs, symptoms, or situations:

Dose: _____ q ☐ 4 hours or ☐ 6 hours as needed (specify)

If no improvement, indicate instructions:

3. ORAL MEDICATION: _____

Preparation/Concentration: _____

Route: _____

Choose all options that are appropriate:
- ☐ Student may carry medication and may self-administer (INCLUDES SCHOOL TRIPS &/OR AFTER-SCHOOL PROGRAMS) (PARENT MUST INITIAL REVERSE SIDE)
- ☐ Medication should be kept in close proximity to student; choose option:
  - ☐ Student to self-administer (PARENT MUST INITIAL REVERSE SIDE).
  - ☐ Nurse to administer

PRN *Specify signs, symptoms, or situations*:

Dose: _____ Time interval: q __ (specify min or hours)

Conditions under which medication should not be given:

If no improvement, indicate instructions:

HOME Medications (include over-the counter)	For DOHMH Only
	Revisions per DOHMH after consultation with prescribing provider. ☐ 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 PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

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

ALLERGIES / ANAPHYLAXIS

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2015–2016

Student Last Name First Name MI	Date of birth __ __ / __ __ / __ __ __ __	School

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the school nurse and the principal and/or his/her designee(s) of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this Authorization is only valid until the earlier of: (1) June 30, 2016 (This prescription may be extended through August if the student is attending a New York City Department of Education ("DOE") sponsored summer instruction program); or (2) such time that I deliver to the school nurse and the principal and/or his/her designee(s) a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed medication. By submitting this MAF, I am requesting that my child be provided with specific health services by DOE and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH"). I understand that part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this MAF. I further understand that the OSH, DOE and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize OSH and DOE and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

**SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications):

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize OSH and DOE, their agents and employees; including the school nurse, principal, his/her designee(s), and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

_____ I also authorize the principal, his/her designee(s) and school nurse to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ I hereby certify that I have consulted with my child's health care provider and that I authorize the Office of School Health to administer stock Ventolin in the event that my child's asthma prescription medication is unavailable.

You must send your child's epinephrine, asthma inhaler and other approved self-administered medications with your child on a school trip day and/or after-school programs *in order that he/she has it available.*

Parent/Guardian's Signature	Print Parent/Guardian's Name
Date Signed __/__/____	Parent/Guardian's Address
Telephone Numbers: Daytime (___)___-____ Home (___)___-____ Cell Phone* (___)___-____	
Parent/Guardian e-mail address*	
Alternate Emergency Contact's Name	Contact Telephone Number (___)___-____
DO NOT WRITE BELOW – FOR DOE AND DOHMH ONLY	
Received by: Name Date __ __ / __ __ / __ __ __ __	Reviewed by: Name Date __ __ / __ __ / __ __ __ __
Self-Administers/Self-Carries: ☐ Yes ☐ No	Services provided by: ☐ Nurse ☐ DOHMH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff
Signature and Title (RN OR MD):	

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

DIABETES MEDICATION ADMINISTRATION FORM – OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication in School to Students for School Year 2015–2016

Student Last Name	First Name	Middle	Date of birth ___/___/____ MM DD YYYY	☐ Male ☐ Female	OSIS # _____
School (include name, number, address and borough)			DOE District ___ ___	Grade	Class

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other Diagnosis: | Recent A1C: Date ___/___/____ Result ___.__ %

EMERGENCY ORDERS

Severe Hypoglycemia

Administer **Glucagon** and **call 911**

☐ 1 mg SC/IM

☐ ___ mg SC/IM

Give PRN: unconsciousness, unresponsiveness, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration.

Risk for Diabetic Ketoacidosis (DKA)

☐ Test **ketones** if hyperglycemic, vomiting, or fever ≥100.5

- If small or trace give water; re-test ketones & bG in ___ hours
- If initial or retest ketones are moderate or large, give water
  - ☐ Call parent and PMD ☐ No Gym
  - ☐ If vomiting, unable to take PO, and MD not available, CALL 911
  - ☐ Give **insulin** correction dose if > _ hours since last insulin.

BLOOD GLUCOSE (bG) MONITORING

☐ Student may check bG without nurse supervision.

☐ Student to check bG with nurse supervision.

☐ Nurse / school personnel must check bG.

INSULIN ADMINISTRATION: STUDENT / SCHOOL NURSE

☐ Student to administer without nurse supervision.

☐ Student to administer with nurse supervision.

☐ Nurse must administer.

MONITORING	☐ At LUNCH Time	☐ At SNACK Time**	☐ At GYM Time	☐ PRN
Hypoglycemia	For bG< ___ mg/dL Give _____ oz juice, or ___ glucose tabs, or ___ grams carbs. Re-check in __ minutes; if bG <___ repeat carbs and re-check until bG >___. THEN Insulin is given BEFORE Lunch, unless otherwise indicated. ☐ Give insulin AFTER Lunch	For bG< ___ mg/dL Give _____ oz juice, or ___ glucose tabs, or ___ grams carbs. Re-check in ___ minutes; if bG <___ repeat carbs and re-check until bG >___. THEN Insulin is given BEFORE Snack,** unless otherwise indicated. ☐ Give insulin AFTER Snack**	For bG< ___ mg/dL Give _____ oz juice, or ___ glucose tabs, or ___ grams carbs. Re-check in __ minutes; if bG <___ repeat carbs and re-check until bG > ___. ☐ If initial bG < ___, No Gym ☐ Give Snack** AFTER treatment THEN send to Gym	For bG< ___ mg/dL Give _____ oz juice, or ___ glucose tabs, or ___ grams carbs. Re-check in __ minutes; if bG <___ repeat carbs and re-check until bG > ___. ☐ Give Snack** after treating hypoglycemia
Between hypo & hyperglycemia	Insulin is given BEFORE Lunch, unless otherwise instructed. ☐ Give insulin AFTER Lunch	Insulin is given BEFORE Snack,** unless otherwise instructed. ☐ Give insulin AFTER Snack**	☐ Give Snack** BEFORE Gym ☐ Send to Gym	
Hyperglycemia bG > ___ mg/dL	Test ketones if bG> ___ mg/dL and manage as above for DKA: applies to all times (otherwise use space in Other Orders) Insulin is given BEFORE Lunch, unless otherwise instructed. ☐ Give insulin AFTER Lunch	Insulin is given BEFORE Snack, ** unless otherwise instructed. ☐ Give insulin AFTER Snack**	☐ For bG> ___. No Gym ☐ For bG> ___. AND at least _ hours since last insulin, give insulin	☐ For bG> ___ No Gym ☐ For bG> ___ AND at least _ hours since last insulin, give insulin
Carb Coverage Insulin Instructions	☐ Carb coverage ONLY ☐ Carb coverage PLUS Correction Dose when bG > Target bG AND at least _hours since last insulin	☐ Carb coverage ONLY ☐ Carb coverage PLUS Correction Dose when bG > Target bG AND at least __hours since last insulin	**SNACK Student may carry and self-administer snacks: ☐ Yes ☐ No Time of day ____ ____ AM ____ ____ PM Type, Amount _____ ☐ NO INSULIN TO BE GIVEN AT SNACK TIME	

INSULIN ORDERS (CHECK ONE)	☐ Carb Coverage PLUS Correction Dose (if ordered) using: ☐ Insulin Sensitivity Factor or ☐ Sliding Scale	☐ Correction Dose ONLY using: ☐ Insulin Sensitivity Factor or ☐ Sliding Scale	☐ Sliding Scale	☐ No Insulin at School Glucose Monitoring ONLY

Name of Insulin: ☐ Syringe ☐ Pen | ☐ Insulin Pump (Brand):

Target bG = ___ mg/dL	Insulin to Carbohydrate Ratio (I:C) For LUNCH: 1 unit: per____ grams carbs For SNACK: 1 unit: per____ grams carbs	Insulin Sensitivity Factor (ISF) 1 unit decreases bG by ___ mg/dL	Basal Rate In School _._ units/hour __ to __ AM / PM _._ units/hour __ to __ AM / PM	Basal Rate for Gym ___._ percent for __hours ☐ Disconnect Pump for gym

Round DOWN insulin dose to the closest 0.5 units for syringe/pen and to the nearest whole unit if the syringe/pen doesn't have half-units unless otherwise instructed by the PCP.

Carb Coverage: # grams carb in meal / # grams carb in I:C = _._ units insulin

Correction Dose by ISF: (bG – Target bG) / Insulin Sensitivity Factor = _._ units insulin

☐ Follow Pump recommendation for bolus dose (If not using Pump recommendation, round dose DOWN to nearest 0.1 unit).

☐ For bG > ___ mg/dL that has not decreased ___ hours after correction, consider pump failure and notify parent, follow sliding scale

☐ For suspected pump failure: DISCONNECT pump and give insulin by syringe or pen.

Sliding Scale

Do NOT overlap ranges (e.g., enter as 0-100, 101-200, etc). If ranges overlap, the lower dose will be given.

☐ Pre-Lunch ☐ Pre-Snack ☐ Correction dose

bG Range mg/dL		Insulin Units
0		

☐ Other time

bG Range mg/dL		Insulin Units
0		

Home Medications	Dose	Frequency	Time
Insulin:			
Oral:			

OTHER ORDERS (such as "Fixed Dose" orders, adjustments for rounding)

Health Care Practitioner (Please Print) LAST NAME	FIRST NAME	Signature
Address	Tel. (___)___-____	Fax. (___)___-____
E-mail address*	Cell* (___)___-____	
NYS License # (Required) _____ Medicaid# ___ ___ ___ ___ ___	NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	Date ___/___/____

The CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

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DIABETES MEDICATION ADMINISTRATION FORM – OFFICE OF SCHOOL HEALTH
Authorization for Administration of Medication in School to Students for School Year 2015–2016

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __	School

MONITORING BLOOD SUGAR, MEDICATION AND DIETARY NEEDS:

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION 2015–2016

I hereby authorize:
(1) the monitoring of my child's blood sugar;
(2) the provision of medically prescribed treatment and/or;
(3) the treatment of hypoglycemic episodes on school premises, in accordance with the attached instructions of his/her physician.

I understand that I must furnish all necessary snacks, equipment and supplies and that I must immediately advise the school nurse, principal and/or his/her designee(s) of any change in the prescription or instructions stated above.

I understand that this Authorization is only valid until the earlier of: (1) June 30, 2016; (This prescription may be extended through August if the student is attending a New York City Department of Education ("DOE") sponsored summer instruction program); or (2) such time that I deliver to the school nurse, principal and/or his/her designee(s) a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed monitoring and treatment.

I recognize that the New York City Department of Health and Mental Hygiene ("DOHMH"), DOE, and their agents have a responsibility to ensure a safe environment in the medical room and anywhere else where my child may test his or her blood sugar. I will make every effort to provide the school with safety lancets and other safer needle devices for the purpose of glucose monitoring and insulin administration.

By submitting this Diabetes Medication Administration Form, I am requesting that my child be provided with specific health services by DOHMH through the Office of School Health ("OSH") .I understand that part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this form. I understand that OSH, their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this form. I further understand that OSH and its agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by OSH or DOE to provide the services requested, but, rather, my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize OSH and DOE and their employees, and agents to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist.

Parent/Guardian's Signature	Print Parent/Guardian's Name
Date Signed __ __ / __ __ / __ __ __ __	Parent/Guardian's Address
Telephone Numbers: Daytime (__ __ __) __ __ __ - __ __ __ __ Home (__ __ __) __ __ __ - __ __ __ __ Cell Phone* (__ __ __) __ __ __ - __ __ __ __	
Parent/Guardian e-mail address*	
Alternate Emergency Contact's Name	Contact Telephone Number (__ __ __) __ __ __ - __ __ __ __
DO NOT WRITE BELOW – FOR DOE AND DOHMH ONLY	
Received by: Name Date __ __ / __ __ / __ __ __ __	Reviewed by: Name Date __ __ / __ __ / __ __ __ __
bG monitoring without supervision: ☐ Yes ☐ No Insulin administration without supervision: ☐ Yes ☐ No	
Services provided by: ☐ Nurse ☐ DOHMH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff	
Signature and Title (RN OR MD):	
Revisions per DOHMH after consultation with prescribing provider.	

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

REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

OFFICE OF SCHOOL HEALTH - School Year 2015–2016

FOR DOE/DOHMH USE:
☐ **504** ☐ **IEP** ☐ **OTHER**

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

Part I: Physician'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 Feeding: ☐ Bolus ☐ Pump ☐ Gravity
- ☐ Gastrostomy Tube replacement if dislodged - specify in area below
- ☐ Naso-Gastric Feeding
- ☐ Oral / Pharyngeal Suctioning
- ☐ Tracheostomy Care Trach. Size _____
- ☐ Trach. suctioning Cath. Size _____
- ☐ Trach replacement - specify in area below
- ☐ Oxygen Administration Liters _____ Via ☐ Trach ☐ Mask ☐ Cannula
- ☐ Pulse Oximetry monitoring
- ☐ Ostomy Care
- ☐ Chest Clapping
- ☐ Percussion
- ☐ Postural Drainage
- ☐ Dressing Change
- ☐ Other_____

Specific instructions for nurse (if one is assigned and present) in case of adverse reactions, including dislodgement of tracheostomy or gastrostomy tube:

Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or gastrostomy tube:

1. Diagnosis — Enter ICD Codes and Conditions (RELATED TO THE DIAGNOSIS) ☐ ___.___ ☐ ___.___
2. Treatment required in school; for Feeding Orders, please provide formula name.
3. Specific instructions for providing treatment (For feeding orders, please provide amount of feeding; duration of feeding; flush type and amount)
4. Frequency/specific time to be provided in school
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. Diagnosis is self- limited ☐ Yes ☐ No

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 __/__/____

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF ORDERS

FOR DOE/DOHMH USE: Revisions as per DOE/ DOHMH contact with prescribing physician.

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

Rev 7/15

REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)
OFFICE OF SCHOOL HEALTH - School Year 2015–2016

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION 2015-2016

I hereby authorize the provision of medically prescribed treatment in accordance with the attached instructions of my child's physician. I understand that I must furnish all necessary equipment and supplies and that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.

I understand that this Authorization is only valid until the earlier of: (1) June 28, 2016; (This prescription may be extended through August if the student is attending a New York City Department of Education (the "Department") sponsored summer instruction program; or (2) such time that I deliver to the principal and/or his/her designee (s) a new prescription or instructions issued by my child's physician regarding the provision of the above-prescribed treatment.

By submitting this Request for Provision of Medically Prescribed Treatment (Non-Medication) Form, I am requesting that my child be provided with specific health services by the Department and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH). Full and complete instructions regarding the provision of the above-requested health service(s) are included in this form. I understand that the Department, DOHMH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this form. I understand that it is my responsibility to provide all equipment and supplies necessary for the provision of the above-requested medically prescribed non-medication treatment.

I recognize that this form is not an agreement by the Department or DOHMH to provide the services requested, but, rather, my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department or DOHMH, and their employees and agents, to contact, consult with and to obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist.

Parent/Guardian's Signature	Print Parent/Guardian's Name
Date Signed __ __ / __ __ / __ __ __ __	Parent/Guardian's Address
Telephone Numbers: Daytime (__ __ __) __ __ __ - __ __ __ __ Home (__ __ __) __ __ __ - __ __ __ __ Cell Phone* (__ __ __) __ __ __ - __ __ __ __	
Alternate Emergency Contact's Name	Alternate Contact's Telephone Number (__ __ __) __ __ __ - __ __ __ __

DO NOT WRITE BELOW – FOR DOE AND DOHMH ONLY			
Student Last Name	First Name	MI	OSIS No: __ __ __ __ __ __ __ __
Received by: Name	Date __ __ / __ __ / __ __ __ __	Reviewed by: Name	Date __ __ / __ __ / __ __ __ __
Referred to School 504 Coordinator: ☐ Yes ☐ No			
Services provided by: ☐ Nurse	☐ DOHMH Public Health Advisor	☐ School Based Health Center	☐ DOE School Staff
Self-Directs Treatment: ☐ Yes	☐ No		
Signature and Title (RN OR SMD):		Date School Notified & Form Sent to DOE Liaison __ __ / __ __ / __ __ __ __	

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

REQUEST FOR SECTION 504 ACCOMMODATIONS –OFFICE OF SCHOOL HEALTH- SCHOOL YEAR 2015-2016

PART 1: REQUEST FOR SECTION 504 EDUCATION ACCOMMODATIONS- To be completed by individual requesting accommodations. Submit to school 504 Coordinator

Date submitted to 504 Coordinator:		DBN:		School Name:	
Name of person submitting request:		Student Name:		Student DOB:	
Relationship to student:		Student ID #:		Grade/Class:	

Describe the concern below and how it affects the student's educational performance:

Indicate accommodations requested based on the concern above. Please consult the school-based 504 Coordinator with any questions.

Request for Educational Accommodation(s) *Check all requested:*		***For school use only***	
		Approve	**Deny**
Testing Accommodations	□ Test schedule/administration time (e.g. extended time, etc.)	□	□
	□ Test setting/location	□	□
	□ Method of presentation/Directions/Assistive Technology	□	□
	□ Method of test response/content support	□	□
	□ Other (please specify)	□	□
Classroom / Curriculum Accommodations	□ Class schedule/use of time	□	□
	□ Class activities setting	□	□
	□ Method of presentation/Directions/Assistive Technology	□	□
	□ Method of class activities response/Content Support	□	□
	□ Other (please specify)	□	□
Academic Supports and Services	□ Paraprofessional services*	□	□
	□ Safety Net *(high school only)*	□	□
	□ Other (please specify)	□	□
Scheduling / Other (?)*	□ Barrier-free site/Use of elevator	□	□
	□ Breaks (e.g. snack, bathroom, etc.)	□	□
	□ Additional time for class transition	□	□
	□ Other (please specify)	□	□

*A separate transportation form must be used for specialized transportation accommodations.

REQUEST FOR SECTION 504 ACCOMMODATIONS –OFFICE OF SCHOOL HEALTH- SCHOOL YEAR 2015-2016

PART 2A: PHYSICIAN REVIEW - To be completed by the student's Health Care Practitioner

Student Information

Name:	
DOB:	

Medical Diagnosis/Disability/ICD-Code/DSM-V Code: _____

Codes:

□ AD – Attention Deficit/Hyperactivity/Conduct	□ CV – Cardiovascular/Syncope	□ MO – Mobility Impairment
□ AL – Allergy/Food/Medication	□ DI – Diabetes/Glycogen Storage	□ NU – Neuro/Epilepsy/Seizures
□ AS – Asthma/Airway Disease	□ EA – Ear/Hearing	□ SK – Skin Disorder
□ BL – Anemia/Blood Disorders	□ EY – Eye/Vision	□ Other
□ CA – Cancer	□ GI - Gastrointestinal	

Describe how the diagnosis/condition affects the student's educational performance and which accommodations are recommended to address the student's needs:
** For and paraprofessional requests, describe how the condition affects the student's need for a paraprofessional.*

Health Care Practitioner Information

DATE completed by physician: _____

Physician Name:		NYS License #:	
Signature:		NPI #:	
Office Address:		Medicaid #:	
City / Zip Code:		Fax:	
Telephone:			

PART 2B: PARENT CONSENT - To be completed by the student's parent/guardian prior to submitting to school 504 Coordinator

To determine whether your child is eligible for accommodations under Section 504 of The Rehabilitation Act of 1973, a school-based 504 team will convene to review your child's records – including the physician's statement above (if applicable), classroom observations and assignments, assessment data, and other information. If your child is eligible to receive accommodations, a 504 Plan will be developed with your input and consent. The 504 Plan may be reviewed at any time, but at a minimum must be reauthorized annually.

By signing this form, you are giving consent to the 504 team to review your child's records and take the necessary steps to determine whether your child is eligible to receive accommodations. You also acknowledge that you have provided full and complete information to the best of your ability and understand that the Office of School Health (OSH), New York City Department of Education (DOE), their agents, and their employees are relying on the accuracy of the information provided to determine whether and to what extent your child may receive accommodations under Section 504. Additionally, you hereby authorize OSH and DOE and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to your child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to your child.

Date:	
Name of parent/guardian (print):	
Signature of parent/guardian:	
Daytime telephone number:	