Medical Forms Packet
2015-2016

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

<table>
<thead>
<tr>
<th>ATTACH STUDENT PHOTO HERE</th>
<th>Student</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in special education programs:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Programs:**
- Dose: __________________ Route: __________________
- Preparation/Concentration: ____________________________________

- Confidential information should not be sent by e-mail
- Rev 4/15

**In School Instructions**
- 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)**

- Revisions per DOHMH after consultation with prescribing provider.

**For DOHMH Only**

In School Instructions
- 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:**

- Confidential information should not be sent by e-mail
- Rev 4/15

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

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

The stock Ventolin is only for use while your child is in the school building.

**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.

<table>
<thead>
<tr>
<th>Parent/Guardian's Signature</th>
<th>Print Parent/Guardian's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Signed</td>
<td>Parent/Guardian’s Address</td>
</tr>
<tr>
<td>Telephone Numbers: Daytime (<strong><strong><strong>) (</strong><strong>) Home (</strong></strong></strong>) (<strong><strong>) Cell Phone* (</strong></strong>)</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian e-mail address*</td>
<td></td>
</tr>
</tbody>
</table>

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-Administrates/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):
**STUDENT HOME MEDICATIONS**

(include over-the-counter)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
</table>

**In School 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.

- **Standing daily dose:**
  - ___ puffs once a day at ___ AM OR ___ PM
  - OR ___ puffs twice a day at ___ AM and ___ PM

**Select In School ASTHMA Medications**

- 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® **

**Other:**

- History of near-death asthma requiring mechanical ventilation
- History of life-threatening asthma (e.g. with loss of consciousness or with hypoxic seizure)
- Received oral steroids within past 12 months: ___ times
- Date last oral steroids received: ___/___/___
- History of food allergy, eczema, specify ________

**Diagnosis**

- **Asthma**
- **Other:**

**Select Asthma Severity and Control**

- **Severity:**
  - Intermittent □
  - Mild Persistent □
  - Moderate Persistent □
  - Severe Persistent □

- **Control:**
  - Well-controlled □
  - Not Controlled □
  - Poorly Controlled □

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

- History of asthma-related:
  - History of death asthma requiring mechanical ventilation
  - PICU admissions (ever)
  - ER visits within past 12 months: ___ times
  - Hospitalizations within past 12 months: ___ times

**Select Controller Medications for In-School Administration**

(Recommended for Persistent Asthma, per NAEP Guidelines)

- Inhaled corticosteroid (ICS) :
  - _______@ with spacer

- ICS combined with long-acting beta agonist: _______®
  - with spacer

**Other:**

- **Student** may carry medication & may self-administer. **
- **Student** to self-administer** personal MDI on school trips and/or after-school programs. **Yes □ No □
- **Student** to self-administer** personal MDI on school trips and/or after-school programs. **Yes □ No □

**PARENTS MUST INITIAL REVERSE SIDE**

**HOME Medications (include over-the-counter)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
</table>

**For DOHMH Only**

- Revisions per DOHMH after consultation with prescribing provider.

- IEP

**Health Care Practitioner**

<table>
<thead>
<tr>
<th>LAST NAME (Please Print)</th>
<th>FIRST NAME</th>
<th>Signature</th>
</tr>
</thead>
</table>

- 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.
## 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 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 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 Information

<table>
<thead>
<tr>
<th>Parent/Guardian's Signature</th>
<th>Print Parent/Guardian's Name</th>
<th>Date Signed</th>
<th>Parent/Guardian's Address</th>
<th>Telephone Numbers: Daytime (___ ___) ___ ___ - ___ ___ ___</th>
<th>Home (___ ___) ___ ___ - ___ ___ ___</th>
<th>Cell Phone* (___ ___) ___ ___ - ___ ___ ___</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Alternate Emergency Contact's Name

<table>
<thead>
<tr>
<th>Alternate Emergency Contact's Name</th>
<th>Contact Telephone Number (___ ___) ___ ___ - ___ ___ ___</th>
</tr>
</thead>
</table>

### Service Providers

- **Self-Administerers/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**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Weight (kg)</td>
</tr>
<tr>
<td>OSIS #</td>
<td>DOE District</td>
</tr>
<tr>
<td>School (include name, number, address and borough)</td>
<td></td>
</tr>
</tbody>
</table>

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

**Specify Allergy**

| History of asthma? | Yes | No |
| History of anaphylaxis? | Yes | No |
| If yes, symptoms | Respiratory | Skin | GI | Cardiovascular | Neurologic |

#### History of skin testing?

| Date __ __ / __ __ / __ __ |

#### Select In School Medications

**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).

#### In School Instructions

**PRN (check all that apply):**

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

**Specify signs, symptoms, or situations:**

**Dose:** _______ q ___ 4 hours or ___ 6 hours as needed (specify)

If no improvement, indicate instructions:

#### HOME Medications (include over-the-counter)

Revisions per DOHMH after consultation with prescribing provider. □ IEP

#### Health Care Practitioner

(Please Print)

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address

Tel. (___ ___) ___ ___ ___ ___ Fax. (___ ___) ___ ___ ___ ___

E-mail address*

Cell* (___ ___) ___ ___ ___ ___

NYS License # (Required) ____________ Medicaid # ____________

NPI # ____________ ____________ ____________ ____________ Date __ __ / __ __ / __ __

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

Rev 4/15

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS
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.
### Diabetes Medication Administration Form – Office of School Health

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

#### Student Information
- **Last Name:** [Last Name]
- **First Name:** [First Name]
- **Middle:** [Middle]
- **Date of birth:** [MM DD YYYY]
- **Gender:**
  - [Male]
  - [Female]
- **OSIS #:** [OSIS #]

#### School Information
- **School (include name, number, address and borough):** [School]
- **DOE District:** [District]
- **Grade:** [Grade]
- **Class:** [Class]

#### Type of Diabetes
- [□ Type 1 Diabetes]
- [□ Type 2 Diabetes]
- **Other Diagnosis:** [Other Diagnosis]

#### Emergency Orders

**Severe Hypoglycemia**
- Administer Glucagon and call 911

**Risk for Diabetic Ketoacidosis (DKA):**
- Test ketones if hyperglycemic, vomiting, 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
- If vomiting, unable to take PO, and MD not available, CALL 911
- Give insulin correction dose if bg > __ hours since last insulin.

#### Blood Glucose (bg) Monitoring

**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 > __

**Between Hypo & hyperglycemia**
- Insulin is given BEFORE Lunch, unless otherwise instructed.
- Give insulin AFTER Lunch

**Hyperglycemia**
- **For 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)
  - Give insulin BEFORE Lunch, unless otherwise instructed.
  - Give insulin AFTER Lunch

**Carb Coverage & Insulin Instructions**
- Carb coverage ONLY
- Carb coverage PLUS Correction Dose when bg > Target bg AND at least __ hours since last insulin

### Sliding Scale

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

**Sliding Scale:***
- **Pre-Lunch**
- **Pre-Snack**
- **Correction dose**

**bG Range mg/dL**
- [0-100]

**Insulin Units**
- [0]

**Other time**
- [0]

#### Incomplete Provider Information Will Delay Implementation of Medication Orders

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

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

---

**Diabetes Medication Administration Form – Office of School Health**

**SH-101 (Rev4/15)**
**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.

<table>
<thead>
<tr>
<th>Parent/Guardian's Signature</th>
<th>Print Parent/Guardian's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Signed</td>
<td>Parent/Guardian's Address</td>
</tr>
</tbody>
</table>

| Telephone Numbers:         |                                 |
| Daytime (___ ___) ___ ___ ___ | Home (___ ___) ___ ___ ___ |
| Cell Phone* (___ ___) ___ ___ ___ |

<table>
<thead>
<tr>
<th>Parent/Guardian e-mail address*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate Emergency Contact’s Name</td>
</tr>
</tbody>
</table>

| 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**

**ATTACH STUDENT PHOTO HERE**

<table>
<thead>
<tr>
<th>Student Last Name</th>
<th>First Name</th>
<th>Middle</th>
<th>Date of birth</th>
<th>Male/Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><em><strong>/</strong></em>/______</td>
<td></td>
</tr>
</tbody>
</table>

**Guardian e-mail address* | OSIS Number ____________

**School (include name, number, address and borough)**

<table>
<thead>
<tr>
<th>DOE District</th>
<th>Grade</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Part I: Physician’s Statement/Order

ONE ORDER PER FORM (make copies of this form for additional orders)

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

| Clean Intermittent Catheterization Cath. Size _____ | Tracheostomy Care Trach. Size _____ | Ostomy Care |
| Central Venous Line | Trach. succioning Cath. Size _____ | Chest Clapping |
| Gastrostomy Feeding: □ Bolus □ Pump □ Gravity | Trach replacement - specify in area below | Percussion |
| Gastrostomy Tube replacement if dislodged - specify in area below | Oxygen Administration Liters _____ | Postural Drainage |
| Naso-Gastric Feeding | Via □ Trach □ Mask □ Cannula | Dressing Change |
| Oral / Pharyngeal Suctioning | Pulse Oximetry monitoring | |
| 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**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>(Please Print)</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Parent/Guardian's Signature</th>
<th>Print Parent/Guardian's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Signed</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian's Address</td>
<td></td>
</tr>
</tbody>
</table>

| 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

<table>
<thead>
<tr>
<th>Student Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>OSIS No: __ ___ __ ___ __ ___</th>
</tr>
</thead>
</table>

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.
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.

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

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

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

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.

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: