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

OFFICE OF SCHOOL HEALTH - School Year 2016-2017

家長/監護人同意信

我謹此授權根據隨附的我子女保健專業人員的說明為我子女提供醫療處方的治療。我理解，我必須負責為所申請的治療提供所有必要的器械和用品，並且我必須立即通知學校護士有關上述處方或說明的任何變化。

我理解，這份同意函的有效期只持續到一個由紐約市教育局（DOE）資助的暑期教學計劃時段結束爲止，或者到我將我子女的保健專業人員簽發的關於上述說明的監督和治療的使用之最新處方或說明交給學校護士這一時間爲止（以這兩者中較早的時間為准）。

我遞交這份「要求提供醫療處方治療的申請表（適用非藥物）」，則表明我申請由教育局與紐約市健康和心理衛生局（New York City Department of Health and Mental Hygiene，簡稱 DOHMH）通過學校健康辦公室（Office of School Health，簡稱 OSH）給我的子女提供具體健康服務。關於上述健康服務提供之要求的全面和完整的說明列入此表。我理解，與上述要求的健康服務的提供相關的教育局、健康和心理衛生局（DOHMH）及其代理機構和僱員需要本表格所提供資訊的精確性。

我知道，這一表格並不是教育局以及健康和心理衛生局（DOHMH）提供所申請的服務的同意函，而是我要求這些服務的申請、同意和授權函。如果這些服務被確定為有必要提供，則一份「學生照顧計劃」（Student Accommodation Plan ）可能也是有必要的，將由學校填寫。

我理解，教育局和健康和心理衛生局（DOHMH）及其僱員和代理機構可以與任何給我子女提供醫療或健康服務的保健專業人員和/或藥劑師聯絡和協商並獲取任何他們認爲與我子女的醫療狀況、藥物和/或療法相關的恰當額外資訊。

****學生自己施用治療法：請在這段簽上您姓名的首字母，讓您的子女可以自己施用處方治療法：**

____ 我謹此證明，我的子女已經獲得全面的指導，有能力自己施用該處方治療法。我也同意我子女在學校自己施用上述處方治療法。我知道，我要負責給我的子女提供如此器械：該器械必須置於如以上所描述而標示的容器中；我要負責對我子女使用此治療法的任何和所有的監督；並負責我子女因在學校自己使用此治療法而導致的任何或所有後果。我理解，學校護士將確認我子女是否具有以負責的方式自己施用治療法的能力。另外，我同意提供一份置於一個清楚標寫的容器中的「後備」器械，該器械將被保存在醫務室，在我子女沒有足夠藥物自己施用的情況下備用。

____ 我同意，萬一我的子女臨時無法自己儲藏和/或自己施用該治療法時，學校護士可以儲存此器械物和/或給我的子女施用該治療法。

家長/監護人簽名	**清楚填寫家長/監護人的姓名**
簽名日期 ＿＿/＿＿/＿＿＿＿	**家長/監護人地址**
電話號碼： **日間**（＿＿＿）＿＿＿- ＿＿＿＿ **住宅**（＿＿＿）＿＿＿- ＿＿＿＿ **手機***（＿＿＿）＿＿＿- ＿＿＿＿	
其他緊急聯絡人姓名	**其他聯絡電話** （＿＿＿）＿＿＿- ＿＿＿＿

DO NOT WRITE BELOW – FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY	
Student Last Name First Name MI	OSIS No:＿＿ ＿＿＿＿＿＿＿
Received by:Name Date ＿＿/＿＿/＿＿＿＿	**Reviewed by**:Name Date ＿＿/＿＿/＿＿＿＿
☐ **504** ☐ **IEP** ☐ **Other**	**Referred to School 504 Coordinator**:☐ Yes ☐ No
Services provided by: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center	
Self-Directs Treatment: ☐ Yes ☐ No	
Signature and Title (RN OR SMD):	**Date School Notified & Form Sent to DOE Liaison** ＿＿/＿＿/＿＿＿＿
FOR Office of School Health (OSH) USE:Revisions as per OSH contact with prescribing health care practitioner.	

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OFFICE OF SCHOOL HEALTH - School Year 2016-2017

ATTACH STUDENT PHOTO HERE	**Student** Last Name First Name Middle	**Date of birth** __/__/____ MM DD YYYY	☐ Male ☐ Female
	Guardian e-mail address*	**OSIS Number** __ _ _ _ _ _ _ _ _	
	School (include name, number, address and borough)	**DOE District** ___ ___	**Grade** / **Class**

Health Care Practitioner's Statement/Order

ONE ORDER PER FORM (make copies of this from for additional orders)
(Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization).

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

Student will also require treatment: ☐ during transport ☐ on school-sponsored trips ☐ during afterschool programs

Select the most appropriate option for this student:

☐ Nurse-Dependent Student: nurse must administer treatment

☐ Independent Student: student is self-carry/self-administer **(NOT ALLOWED FOR CONTROLLED SUBSTANCES)**: **PARENT MUST INITIAL REVERSE SIDE**
I attest student demonstrated the ability to self-administer the prescribed treatment effectively for school/field trips/school-sponsored events _____
Practitioner's initials

1. Diagnosis — Enter ICD Codes and Conditions (RELATED TO THE DIAGNOSIS)

☐ _ _ _ . _ _ _ ☐ _ _ _ . _ _ _

Diagnosis is self- limited ☐ Yes ☐ No

2. Treatment required in school:
Feeding: _____ _____ _____ _____ _____ _____
Formula Name / Concentration / Route / Amount/Rate / Duration / Frequency/specific time(s) of administration

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

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

Additional Instructions or Treatment:

3. Conditions under which treatment should not be provided:

4. Possible side effects/adverse reactions to treatment:

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

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

7. Date(s) when treatment should be: Initiated __ __ / __ __ / __ __ __ __ terminated __ __ / __ __ / __ __ __ __

Health Care Practitioner LAST NAME FIRST NAME (Please Print)			Signature
Address	Tel. No. (_ _ _) _ _ _ - _ _ _ _		Fax. No (_ _ _) _ _ _ - _ _ _ _
E-mail address*			Cell phone* (_ _ _) _ _ _ - _ _ _ _
NYS License No **(Required)** __ - __ __ __ __	Medicaid No __ __ __ __ __ __	NPI No __ __ __ __ __ __ __ __	Date __/__/____

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

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