

MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS
 Provider Medication Order Form | Office of School Health | School Year **2018-2019**
DUE: JULY 15th. Forms submitted after July 15th may delay processing for new school year.

Attach student photo here

Student Last Name _____	First Name _____	Middle _____	Date of birth ____/____/____ MM DD YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
OSIS Number _____				
School (include name, number, address and borough)			DOE District	Grade
Class _____				

HEALTH CARE PRACTITIONERS COMPLETE BELOW

<p>1. Diagnosis: _____ ICD-10 Code: <input type="checkbox"/> _____</p> <p>Medication: _____ Generic and/or Brand Name Preparation/Concentration: _____ Dose: _____ Route: _____</p> <p>Student Skill Level (Select the most appropriate option): <input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised Student: student self-administers, under adult supervision <input type="checkbox"/> Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES)</p> <p><input type="checkbox"/> I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.</p> <p>Practitioner's Initials _____</p>	<p><u>In School Instructions</u> <input type="checkbox"/> Standing daily dose: at ____:____ AM / PM and ____:____ AM / PM AND/OR <input type="checkbox"/> PRN _____ _____ <i>specify signs, symptoms, or situations</i></p> <p><input type="checkbox"/> Time interval: __ minutes or __ hours as needed. <input type="checkbox"/> If no improvement, repeat in __ minutes or __ hours for a maximum of __ times.</p> <p><u>Conditions under which medication should not be given:</u> _____</p>
<p>2. Diagnosis: _____ ICD-10 Code: <input type="checkbox"/> _____</p> <p>Medication: _____ Generic and/or Brand Name Preparation/Concentration: _____ Dose: _____ Route: _____</p> <p>Student Skill Level (Select the most appropriate option): <input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised Student: student self-administers, under adult supervision <input type="checkbox"/> Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES)</p> <p><input type="checkbox"/> I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.</p> <p>Practitioner's Initials _____</p>	<p><u>In School Instructions</u> <input type="checkbox"/> Standing daily dose: at ____:____ AM / PM and ____:____ AM / PM AND/OR <input type="checkbox"/> PRN _____ _____ <i>specify signs, symptoms, or situations</i></p> <p><input type="checkbox"/> Time interval: __ minutes or __ hours as needed. <input type="checkbox"/> If no improvement, repeat in __ minutes or __ hours for a maximum of __ times.</p> <p><u>Conditions under which medication should not be given:</u> _____</p>
<p>3. Diagnosis: _____ ICD-10 Code: <input type="checkbox"/> _____</p> <p>Medication: _____ Generic and/or Brand Name Preparation/Concentration: _____ Dose: _____ Route: _____</p> <p>Student Skill Level (Select the most appropriate option): <input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised Student: student self-administers, under adult supervision <input type="checkbox"/> Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES)</p> <p><input type="checkbox"/> I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.</p> <p>Practitioner's Initials _____</p>	<p><u>In School Instructions</u> <input type="checkbox"/> Standing daily dose: at ____:____ am / pm and ____:____ AM / PM AND/OR <input type="checkbox"/> PRN _____ _____ <i>specify signs, symptoms, or situations</i></p> <p><input type="checkbox"/> Time interval: __ minutes or __ hours as needed. <input type="checkbox"/> If no improvement, repeat in __ minutes or __ hours for a maximum of __ times.</p> <p><u>Conditions under which medication should not be given:</u> _____</p>

HOME Medications (include over-the counter)

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

**FÒM POU MANDE BAY MEDIKAMAN
YO PA TA DWE ITILIZE FÒM SA A POU MEDIKAMAN KONT OPRESYON OSWA ALÈJI.**

Fòm Kòmand Medikaman Founisè | Biwo Sante Lekòl | Ane Lekòl 2018–2019
DELE : 15 JIYÈ. Fòm yo resevwa apre 15 jiyè ka retade pwosesis la pou nouvo ane lekòl la
PARAN/RESPONSAB RANPLI PATI PI BA A

Lè m siyen pi ba, mwen dakò avèk bagay sa yo:

- Mwen dakò pou yo konsève medikaman pitit mwen ak ba li yo nan lekòl la dapre eksplikasyon doktè pitit mwen an bay. Mwen dakò tou pou yo konsève nenpòt ekipman yo bezwen pou yo ka konsève medikaman pitit mwen an ak itilize l nan lekòl la.
- Mwen konprann ke:
 - Mwen dwe bay enfimye lekòl la medikaman ak ekipman pitit mwen an.
 - Tout medikaman ak preskripsyon ak tout medikaman “ki vann san preksripsyon (over-the-counter)” fèt pou nèf, kachte nan bwat oswa boutèt orijinal la.** M ap gen yon lòt medikaman pou pitit mwen pran lè li pa lekòl oswa lè li nan yon pwomnad lekòl.
 - Medikaman ki vann ak preskripsyon yo fèt pou gen etikèt orijinal famasi a sou bwat la oswa sou boutèt la. Etikèt la dwe gen ladan: 1) non pitit mwen an, 2) non ak nimewo telefòn famasi a, 3) non doktè pitit mwen an, 4) dat, 5) kantite rechaj (refills), 6) non medikaman an, 7) dozaj, 8) lè pou li pran l, 9) kòman pou li pran medikaman an ak 10) nenpòt lòt eksplikasyon.
 - Mwen dwe di enfimye lekòl la imedyatman nenpòt chanjman ki genyen nan medikaman pitit mwen an oswa nan eksplikasyon doktè k ap trete l.
 - Yo pa pèmèt okenn elèv pote oswa pran dwòg ilegal poukont yo.**
 - Biwo Sante nan Lekòl (Office of School Health, OSH) ak ajan li ki patisipe nan ofri pitit mwen an sèvis sante ki pi wo yo konte sou presizyon ki nan enfòmasyon ki sou fòm sa a.
 - Lè m siyen fòm pou bay medikaman sa a (medication administration form, MAF) sa a, OSH ka bay pitit mwen an sèvis sante. Sèvis sa yo ka genyen yon evalyasyon klinik oswa yon konsiltasyon medikal yon doktè oswa yon enfimye OSH fè.
 - Lòd pou bay medikaman ki sou fòm MAF sa a ekspire nan fen ane lekòl pitit mwen an, ki ka gen ladan tou sesyon ete, oswa lè mwen bay enfimye lekòl la yon nouvo fòm MAF (kèlkeswa sa ki rive avan an).
 - Fòm sa a reprezante konsantman m ak demand mwen fè pou sèvis medikaman yo dekri sou fòm sa a. se pa yon akò OSH genyen pou li bay sèvis ou mande a. Si OSH deside ofri sèvis sa yo, pitit mwen an ka bezwen tou yon Plan Akomodasyon pou Elèv (Student Accommodation Plan). Se lekòl la k ap ranpli plan sa a.
 - OSH ka gen nenpòt lòt enfòmasyon yo panse ki nesèsè sou pwoblèm medikal pitit mwen an, medikaman l ap pran oswa tertman l swiv. OSH ka pran enfòmasyon sa a nan men nenpòt doktè, enfimye oswa famasyen ki bay pitit mwen an sèvis.
 - Si enfimye lekòl la pa disponib, yo ka avèti m pou m vin lekòl la pou bay pitit mwen an medikaman.

MEDIKAMAN POU TIMOUN LAN PRAN POUKONT LI :

- Mwen sètifye/konfime pitit mwen an resevwa bon jan trening epi li kapab pran medikaman poukont li. Mwen dakò pou pitit mwen an pote, konsève ak pran poukontli medikaman yo preskri nan fòm sa a nan lekòl la. Mwen gen responsablite pou bay pitit mwen an medikaman sa a nan boutèt oswa nan bwat yo jan yo dekri sa pi wo a. Mwen gen responsablite pou m sipèvizite itilizasyon medikaman pitit mwen an ak pou tout konsekans ki genyen nan itilizasyon medikaman pitit mwen an pran nan lekòl la. Enfimye lekòl la pral konfime kapasite pitit mwen an pou l pote ak pran medikaman yo poukont li. Mwen dakò tou pou m bay lekòl la medikaman “an rezèv” nan yon bwat oswa boutèt ki gen etikèt byen klè sou li.
- Mwen dakò pou enfimye lekòl la oswa manm estaf ki resevwa trening bay pitit mwen an medikaman si li pa kapab pote ak pran yo poukont li pou yon ti tan.

SONJE: Li pi bon si w voye medikaman ak ekipman pou pitit ou a nan jou yon pwomnad lekòl ak nan aktivite k ap fèt andeyò lokal lekòl la.

Siyati elèv la	Non	Inisyèl dezyèm non	Dat nesans	Lekòl
Ekri ak Non Paran/Responsab la byen klè	SIYEN LA A		Siyati paran/responsab	
Dat ou siyen fòm lan	Imèl paran/responsab la		Adrès Paran/Responsab	
Nimewo telefòn: Lajounen	Kay		Selilè	
Lòt non moun nou ka kontakte lè gen yon ijans			Nimewo telefòn moun pou kontakte	

For Office of School Health (OSH) Use Only / Pou Itilizasyon Biwo Sante Lekòl Sèlman

OSIS Number:			
Received by: Non		Dat	
Moun ki revize l: Non		Dat	
<input type="checkbox"/> 504	<input type="checkbox"/> IEP	<input type="checkbox"/> Other	Referred to School 504 Coordinator: <input type="checkbox"/> Yes <input type="checkbox"/> No
Services provided by: <input type="checkbox"/> Nurse/NP		<input type="checkbox"/> OSH Public Health Advisor	<input type="checkbox"/> School Based Health Center
(For supervised students only)			
Signature and Title (RN OR SMD):		Date School Notified & Form Sent to DOE Liaison	
Revisions as per OSH contact with prescribing health care practitioner <input type="checkbox"/> Modified <input type="checkbox"/> Not Modified			

*Ou pa dwe voye enfòmasyon konfidansyèl pa imèl.