ALLERGIES / ANAPHYLAXIS

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2016–2017

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

KONSANTMAN PARAN/RESPONSAB

Nan dokiman sa a, mwen bay otorizasyon pou yo bay pitit mwen an medikaman li ak pou yo mete medikaman an ansanm avèk ekipman nesesè pou ba l medikaman an nan kabinè enfimri lekòl la, dapre rekòmandasyon doktè pitit mwen an. Mwen rekonèt mwen dwe bay lekòl la medikaman an ak ekipman nesesè pou bay li, tankou ponp pou opresyon non-Ventolin inhalers. Mwen rekonèt mwen dwe bay medikaman an nan flakon famasi vann li a ak tout etikèt li (mwen dwe mande famasi a yon lòt flakon orijinal pou pitit mwen itilize nan lekòl la); etikèt ki sou medikaman doktè preskri a dwe gen non elèv la, non ak nimewo telefòn famasi a, non doktè ki preskri medikaman an, dat ak kantite fwa yo ka renouvle preskripsyon an, non medikaman an, dòz yo preskri a, kantite fwa pou yo bay timoun lan medikaman an, jan pou yo bay li ak/oswa lòt enstriksyon; yo dwe kite medikaman yo vann san preskripsyon ak echantiyon medikaman nan flakon orijinal fabrikan an yo, avèk non elèv la sou flakon an. Mwen konprann tout medikaman m ap pote dwe nan bwat orijinal medikaman an KI POKO OUVRI. Mwen konprann tou ke mwen dwe fè enfimyè lekòl la konnen si gen yon chanjman nan preskripsyon oswa eksplikasyon ki pi wo a.

Mwen rekonèt yo p ap kite okenn elèv pote oswa pran poukont yo medikaman trankilizan.

Mwen konprann konsantman sa a valab jis nan fen sesyon pwogram ansèyman pandan ete Depatman edikasyon Vil Nouyòk la sèlman; oswa lè mwen bay enfimyè lekòl la yon nouvo preskripsyon oswa enstriksyon doktè pitit mwen an bay (nenpòt sa ki vin avan an). Depi mwen soumèt MAF sa a, mwen mande pou DOE ak Depatman Sante ak Ijyèn mantal vil Nouyòk New York City Department of Health and Mental Hygiene (DOHMH) bay pitit mwen an sèvis sante espesifik pa entèmedyè Biwo Sante nan lekòl Office of School Health (OSH). Mwen konprann sèvis sa yo ka genyen yon evalyasyon klinik ak yon konsiltasyon fizik yon ajan swen sante OSH ap fè. Nou mete tout enstriksyon konsènan fason pou ofri sèvis sante yo mande pi wo a nan MAF sa a an detay. Mwen konnen OSH ak reprezantan yo, ak anplwaye k ap ede ofri sèvis sante yo mande pi wo a konte sou presizyon enfòmasyon moun bay nan fòm sa a.

Mwen rekonèt fòm sa a pa reprezante yon kontra OSH ak DOE pou bay sèvis mwen mande yo, men li reprezante pito demann mwen fè pou sèvis sa yo ak konsantman mwen pou pitit mwen an resevwa sèvis sa yo. Si yo wè sèvis sa yo nesesè, li ka nesesè tou pou tabli yon plan akomodasyon pou elèv la, epi lekòl la ap fè plan.

Mwen konprann OSH ak DOE ak anplwaye yo, ak moun ki reprezante yo kapab kontakte, mande avi tout founisè sèvis sante ak/oswa famasyen ki founi pitit mwen an sèvis sante ak/oswa tretman pou jwenn tout lòt enfòmasyon yo ka jije apwopriye osijè eta sante pitit mwen an, medikaman li pran ak/oswa tretman y ap ba li.

****MEDIKAMAN POU TIMOUN LAN PRAN POUKONT LI : Mete inisyal ou akote paragraf sa a pou itilizasyon yon *epinephrine*, ponp medikaman pou opresyon ak lòt medikaman yo apwouve pou timoun lan pran poukont li):**

____ Mwen sètifye la a yo byen montre pitit mwen an jan pou l pran medikaman yo preskri l la poukont li, epi li ka pran l poukont li. Mwen konsanti tou pou pitit mwen an pote, konsève ak pran medikaman ki preskri pi wo a poukont li nan lekòl la. Mwen rekonèt se responsablite m pou bay pitit mwen an medikaman sa a nan flakon ki gen etikèt jan yo dekri sa pi wo a, pou kontwole jan pitit mwen ititlize medikaman sa a, epitou pou nenpòt konsekans ki rive akoz pitit mwen ap ititlize medikaman sa a nan lekòl la. Mwen konnen enfimyè lekòl la ap konfime kapasite pitit mwen an pou pote ak pou pran medikaman an poukont li yon fason responsab. Anplis, mwen dakò pou bay lekòl la "lòt flakon" medikaman ki gen etikèt kote yo ekri aklè non medikaman an pou konsève nan enfimri lekòl la si pitit mwen an pa ta rete ase nan medikaman li pote pou pran poukont li.

____ Mwen bay konsantman m pou enfimyè lekòl la pou kenbe nan lekòl la ak/oswa bay pitit mwen an medikaman sa a nan ka kote pitit mwen an pa ta kapab kenbe oswa pran medikaman sa pou kont li pou yon ti bout tan.

_____ **Mwen sètifye, nan dokiman sa a, mwen pale avèk ajan swen sante pitit mwen an, epi mwen bay konsantman m pou biwo sante nan lekòl la ba pitit mwen an epinephrine ki disponib nan lekòl la nan ka kote epinephrine yo preskri pitit mwen an pa ta disponib.**

Ou dwe voye pitit ou a avèk epinephrine, ponp opresyon ak lòt medikaman li gen pou pran poukont li *nan* ***pwomnad lekòl la*** ak/oswa pwogram aprelekòl *pou li ka genyen li disponib. Yo ka itilize epinephrine lekòl la genyen an* ***sèlman*** *lè pitit ou a nan bilding lekòl la.*

Siyati Paran/Responsab	**Ekri ak lèt detache Non Paran/Responsab**
Dat ou siyen fòm lan __/__/____	**Adrès Paran/Responsab**
Nimewo telefòn:Lajounen (___)___-____ **Lakay** (___)___-____ **Selilè*** (___)___-____	
Adrès imèl Paran/Responsab*	
Lòt non moun nou ka kontakte lè gen yon ijans	**Nimewo telefòn lòt moun nou ka kontakte a** (___)___-____
PA EKRI PI BA A – PLAS SA A REZÈVE POU ANPLWAYE OSH SÈLMAN (DO NOT WRITE BELOW – FOR OSH USE ONLY)	
Received by: Name Date __/__/____	**Reviewed by**: Name Date __/__/____
Self-Administers/Self-Carries: ☐ Yes ☐ No	**Services provided by**: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff
Signature and Title (RN OR MD/DO/NP):	

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

ALLERGIES / ANAPHYLAXIS

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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 PRACTITIONER**

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
☐ Epinephrine Auto-Injector 0.3 mg
☐ Give antihistamine in addition to epinephrine (**must order antihistamine below)**

Select the most appropriate option for this student:

☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer **

- I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events _____ practitioner's initials

**PARENT MUST INITIAL REVERSE SIDE

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 _____

Select the most appropriate option for this student:

☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer **

- I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events _____ practitioner's initials

**PARENT MUST INITIAL REVERSE SIDE

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 _____

Select the most appropriate option for this student:

☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer **

- I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events _____ practitioner's initials

**PARENT MUST INITIAL REVERSE SIDE

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 Office of School Health (OSH) Use Only**
	Revisions per OSH after consultation with prescribing practitioner. ☐ 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 PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

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