MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD BE USED FOR NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY

Provider Medication Order Form—Office of School Health—School Year **2017–2018**

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

The following sections to be completed by Student's **HEALTH CARE PRACTITIONER**

1. Diagnosis: _____ ICD-10 Code ☐ _ _ _ . _ _ _

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ 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 (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**

_____ Practitioner's initials	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE

In School Instructions

☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM

AND/OR

☐ PRN

_____
specify signs, symptoms, or situations

☐ Time interval: _ _ minutes or _ _ 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: _____ ICD-10 Code ☐ _ _ _ . _ _ _

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ 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 (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**

_____ Practitioner's initials	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE

In School Instructions

☐ Standing daily dose: at _ _: _ _ AM / PM and _ _: _ _ AM / PM

AND/OR

☐ PRN

_____
specify signs, symptoms, or situations

☐ Time interval: _ _ minutes or _ _ 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: _____ ICD-10 Code ☐ _ _ _ . _ _ _

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ 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 (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**

_____ Practitioner's initials	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE

In School Instructions

☐ Standing daily dose: at _ _: _ _ am / pm and _ _: _ _ AM / PM

AND/OR

☐ PRN

_____
specify signs, symptoms, or situations

☐ Time interval: _ _ minutes or _ _ 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 Office of School Health (OSH) Use Only**
	Revisions per OSH after consultation with prescribing health care practitioner. ☐ IEP

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

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

TURN TO PAGE 2 ➔

MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD BE USED FOR NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY

Provider Medication Order Form—Office of School Health—School Year **2017–2018**

The Following Section To Be Completed By Student's Parent/Guardian

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 medikaman, 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 mwen dwe remèt tout medikaman nan bwat orijinal yo ki POKO OUVRI. Mwen rekonèt tou mwen dwe avèti enfimyè lekòl la imedyatman si gen nenpòt chanjman nan preskripsyon an oswa nan enstriksyon ki pi wo a.

Mwen rekonèt yo p ap kite okenn elèv ni pote ni pran medikaman preskripsyon.

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 DOE ni DOHMH 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 elèv la genyen yon Plan akomodasyon epi se lekòl la k ap devlope plan sa a. Mwen konprann Depatman an ak DOHMH 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:

_____ INISYAL	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.
_____ INISYAL	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.

SIYEN LA A

Siyati **elèv** la	Non	MI	Dat nesans	Lekòl
Ekri ak lèt detache Non Paran/Responsab			**Siyati paran/responsab**	
Adrès Paran/Responsab			Dat ou siyen fòm lan	
Nimewo telefòn	Lajounen	Kay		Selilè
Adrès imèl paran an/responsab legal				
Lòt non moun nou ka kontakte lè gen yon ijans			Nimewo telefòn moun pou kontakte	

For OFFICE OF SCHOOL HEALTH (OSH) Only

Received by: Name Date	**Reviewed by**: Name Date
Referred to School 504 Coordinator: ☐ Yes ☐ No	**Self-Administers/Self-Carries:** ☐ Yes ☐ No
Services provided by: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center	
Signature and Title (RN OR MD/DO/NP):	**Date School Notified & Form Sent to DOE Liaison**

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