Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

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

Student Last Name	First Name	Middle	**Date of birth** __ __ / __ __ / __ __ __ __ MM DD YYYY	☐ Male ☐ Female
OSIS Number __ __ __ __ __ __ __ __ __	**Weight** _____kg			
School (include name, number, address and borough)			**DOE District**	**Grade** / **Class**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

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 *(See 'Student Skill Level' below)*	☐ Yes	☐ No
If yes, system affected	☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic		Recognize signs of allergic reactions	☐ Yes	☐ No
Treatment	Date __ __ / __ __ / __ __ __ __		Recognize/avoid allergens independently	☐ Yes	☐ No
History of allergy testing?	☐ Yes *(attach copy of results)* Date __ __ / __ __ / __ __ __ __	☐ No	Comments:		

Select In School Medications

1. SEVERE REACTION

- **CALL 911**, Immediately administer:

☐ **Epinephrine** Auto-Injector 0.15 mg

☐ **Epinephrine** Auto-Injector 0.3 mg (retractable devices preferred) intramuscularly into the anterolateral of thigh for the following symptoms:

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Feeling of doom, confusion, altered consciousness or agitation

☐ Other:_____

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____
Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

- If no improvement, or if symptoms recur, repeat in _____ minutes for maximum of _____ times (not to exceed a total of 3 doses)

Student Skill Level *(select the most appropriate option)*	**Practitioner's Initials**	
☐ Dependent Student: nurse/nurse-trained staff must administer ☐ 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/fieldtrips/school sponsored events.

2. MILD REACTION:

- Give antihistamine: Name:_____Preparation/Concentration:_____ Dose:_____ Route: _____
  Frequency: ☐ **Q4** hours **or** ☐ **Q6** hours as needed for the following symptoms:
  - Itchy nose, sneezing, itchy mouth
  - A few hives
  - Mild stomach nausea or discomfort
  - Other: _____
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine.

Student Skill Level *(select the most appropriate option)*	**Practitioner's Initials**	
☐ Dependent Student: nurse must administer ☐ 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/fieldtrips/school sponsored events.

3. OTHER MEDICATION (e.g., inhaler/bronchodilator if child has asthma):

- Give Name:_____Preparation/Concentration:_____ Dose: _____
  Route:_____ Frequency: Q_____ ☐ minutes ☐ hours as needed

Specify signs, symptoms, or situations:_____
If no improvement, indicate instructions:_____
Conditions under which medication should not be given: _____

Student Skill Level *(select the most appropriate option)*	**Practitioner's Initials**	
☐ Nurse-Dependent Student: nurse must administer ☐ 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/fieldtrips/school sponsored events.

Home Medications *(include over-the counter)*

Health Care Practitioner Name LAST FIRST (Please Print)	Signature	Date __ __ / __ __ / __ __ __ __
Address	Tel. (___) ___ - ____	Fax. (___) ___ - ____
NYS License # **(Required)**	NPI # __ __ __ __ __ __ __ __ __ __	

過敏/過敏反應症的藥物施用表 (MAF)

提供者醫療手續執行表 | 學校健康辦公室 | 2018-2019 學年

截止日期：7 月 15 日。7 月 15 日之後遞交的表格可能延遲受理新學年服務的申請。

家長/監護人填妥以下內容。

在下面簽名，則表示我同意：

1. 我同意，學校保存我子女的醫藥並根據我子女的保健專業人員的說明給葯。我也同意，我子女的醫藥所需的任何器材都在學校裏儲存和使用。
2. 我理解：
   - 我必須把我子女的醫藥和器材交給學校護士。我將盡量給學校有伸縮針頭的腎上腺素注射器（epinephrine pens with retractable needles）。
   - **我所給予學校的所有處方和非處方藥物都必須是新的、未曾打開過並裝在其原封瓶子或盒子裏。**我將給子女另外再獲取一份藥物，供其在不上學時或在參加學校旅行時使用。
     - 處方藥物必須在其盒子或瓶子上有本來的藥房標籤。標籤必須包括：1) 我子女的姓名， 2) 藥房名稱和電話號碼， 3) 我子女的保健專業人員姓名， 4) 日期， 5) 重配次數， 6) 藥物名稱， 7) 劑量， 8) 何時用藥， 9) 如何用藥 以及 10) 任何其它說明。
   - 如果我子女的藥物發生任何變化或者保健專業人員的說明有任何變化，我必須**立即**告知學校護士。
   - 涉及到給我子女提供上述健康服務的學校健康辦公室（OSH）及其代理人員依賴於本表資訊的精確度。
   - 我在這一「藥物施用表」（Medication Administration Form，簡稱 MAF）上簽名，則學校健康辦公室（Office of School Health，簡稱 OSH）可以為我子女提供健康服務。這些服務可以包括由一名 OSH 辦公室保健專業人員或護士所執行的一次臨床評估或一次體檢。
   - 這份 MAF 表的醫療執行手續的過期時間是我子女的學年結束（這可能包括暑期班）或者當我交給學校護士一份新的 MAF（取兩者中較早的那個時間）。
   - 這份表格代表我對本表所說明的過敏服務的同意和要求。這並非 OSH 提供所要求的服務的協議。如果 OSH 決定提供這些服務，我子女可能還需要一份「學生特別照顧計劃」（Student Accommodation Plan）。這份計劃將由學校填寫。
   - OSH 可以獲取該辦公室認爲有關我子女的醫療狀況、藥物和治療而需要的任何其它資訊。OSH 可以從任何為我子女提供健康服務的保健專業人員、護士或藥劑師那裏獲取該資訊。
   - 如果學校護士不在，我可能會被通知前來學校為子女給藥。

自己用藥：

- 我證明/確認，我子女已得到完全的訓練並能夠自行用藥。我同意，我子女在學校裏自己攜帶、儲存本表所開具的藥物並將自己用藥。我負責根據上述說明把瓶子或盒子裏的藥物交給我子女。我也負責監督我子女在學校裏的藥物使用情況及其對這一藥物使用所產生的任何結果。學校護士將確認我子女擁有攜帶和自行用藥的能力。我也同意交給學校「備用」藥物（裝在清楚地標示的盒子或瓶子裏）。
- 我同意，如果我子女臨時不能攜帶或自行用藥，學校護士或經過訓練的學校員工可以給我子女施用藥物。
- 我謹此證明/確認，我已諮詢我子女的保健專業人員，並且我同意學校健康辦公室在萬一我子女沒有哮喘或腎上腺素藥物之際可以給我子女施用儲存的藥物。

說明：如果您決定使用儲存的藥物，則您必須在您子女參加學校外出參觀的日子以及/或者課後計劃時讓子女帶上 epinephrine、哮喘吸入器以及其他獲准的自我施用藥物，以備您子女使用。儲存的藥物只是由 OSH 員工在學校使用。

學生姓氏 名字 MI		出生日期	學校
清楚填寫家長/監護人的姓名	**在此簽名**	**家長/監護人簽名**	
簽名日期	**家長/監護人電子郵箱**	**家長/監護人地址**	
電話號碼日間	**住家**	**手機**	
其他緊急聯絡人姓名		**聯絡電話號碼**	

For Office of School Health (OSH) Use Only / 僅由學校健康辦公室填寫

OSIS Number:			
Received by: Name	Date	**Reviewed by**: Name	Date
☐ **504** ☐ **IEP** ☐ **Other**		**Referred to School 504 Coordinator**: ☐ Yes ☐ No	
Services provided by: ☐ Nurse/NP	☐ OSH Public Health Advisor *(For supervised students only)*	☐ School Based Health Center	
Signature and Title (RN OR SMD):		**Date School Notified & Form Sent to DOE Liaison**	
Revisions as per OSH contact with prescribing health care practitioner ☐ Modified ☐ Not Modified			

*請不要使用電子郵件發送保密資訊