



Attach student photo here

GENERAL MEDICATION ADMINISTRATION FORM
THIS FORM SHOULD NOT BE USED FOR SEIZURE, ASTHMA OR ALLERGY MEDICATIONS
 Provider Medication Order Form | Office of School Health | School Year **2020-2021**
 Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

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

HEALTH CARE PRACTITIONERS COMPLETE BELOW

1. Diagnosis: _____ ICD-10 Code: _____

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level (Select the most appropriate option):
 Nurse-Dependent Student: nurse must administer medication
 Supervised Student: student self-administers, under adult supervision
 Independent Student: student is self-carry / self-administer
Initial below for Independent (Not allowed for controlled substances)

I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

In School Instructions *(please specify AM / PM)*

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: _____

Student Skill Level (Select the most appropriate option):
 Nurse-Dependent Student: nurse must administer medication
 Supervised Student: student self-administers, under adult supervision
 Independent Student: student is self-carry / self-administer
Initial below for Independent (Not allowed for controlled substances)

I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

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: _____

Student Skill Level (Select the most appropriate option):
 Nurse-Dependent Student: nurse must administer medication
 Supervised Student: student self-administers, under adult supervision
 Independent Student: student is self-carry / self-administer
Initial below for Independent (Not allowed for controlled substances)

I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

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)

Health Care Practitioner Name LAST _____ FIRST _____	Signature _____	Date ____/____/____
Please print and circle one: MD DO NP PA	Tel. (____) _____ - _____	Fax. (____) _____ - _____
Address _____		
NYS License # (Required) _____	NPI # _____	

