Attach student photo here

MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION) FORM

Provider Treatment Order Form | Office of School Health | School Year **2023-2024**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female OSIS Number: _____ Grade: _____ Class: _____

DOE District: _____ School (include ATSDBN/name, address, and borough):_____

HEALTHCARE PRACTITIONERS COMPLETE BELOW

ONE ORDER PER FORM (make copies of this from for additional orders). Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization.

- ☐ Blood Pressure Monitoring
- ☐ Chest Clapping/Percussion
- ☐ Clean Intermittent Catheterization: Cath Size _____ Fr.
- ☐ Central Line/PICC Line
- ☐ Dressing Change
- ☐ Feeding: Cath Size _____ Fr.
  - ☐ Nasogastric ☐ G-Tube ☐ J-Tube
  - ☐ Bolus ☐ Pump ☐ Gravity ☐ Spec./Non-Standard*
- ☐ Feeding Tube replacement if dislodged - specify in #5
- ☐ Oral / Pharyngeal Suctioning: Cath Size _____ Fr.
- ☐ Ostomy Care
- ☐ Oxygen Administration - specify in #2
- ☐ Postural Drainage
- ☐ Pulse Oximetry monitoring
- ☐ Trach Care: Trach. Size _____
- ☐ Trach Replacement - specify in #5
- ☐ Trach suctioning: Cath Size ___Fr
- ☐ Other: _____

Student will also require treatment: ☐ during transport ☐ on school-sponsored trips ☐ during afterschool programs

Student Skill Level *(Select the most appropriate option)*:

- ☐ Nurse-Dependent Student: nurse must administer treatment
- ☐ Supervised Student: student self-treats under adult supervision
- ☐ Independent Student: student is self-carry/self-treat (initial below)

☐ I attest student demonstrated the ability to self-administer the prescribed treatment effectively during school, field trips, and school-sponsored events

_____
Practitioner's initials

Diagnosis: _____ Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS)

Diagnosis is self- limited: ☐Yes ☐ No ☐ ____._____ ☐ ____._____ ☐ ____._____

1. Treatment required in school:

☐ **Feeding**: Formula Name: _____ Concentration: _____

Route: _____ Amount/Rate: Duration: _____ Frequency/specific time(s) of administration: _____

***Per the New York State Education Department, nurses are not permitted to administer premixed medications and feedings. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.**

☐ **Flush** with _____ mL _____ ☐ Before feeding ☐ After feeding

☐ **Oxygen Administration**: Amount (L): _____ Route: _____ Frequency/specific time(s) of administration: _____

☐ prn ☐ O2 Sat < _____ % Specify signs & symptoms:

☐ **Other Treatment**: Treatment Name: _____ Route: _____Frequency/specific time(s) of administration: _____

Specify signs & symptoms:

☐ **Additional Instructions or Treatment:**

2. Conditions under which treatment should not be provided:

3. Possible side effects/adverse reactions to treatment:

4. Emergency Treatment: Provide specific instructions for OSH/SBHC clinical staff (if present) in case of emergency or adverse reactions, including dislodgement or blockage of tracheostomy or feeding tube:

5. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:

6. Date(s) when treatment should be: Initiated: _____ Terminated: _____

Health Care Practitioner

Last Name: _____ First Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA

Address: _____

Tel. No: _____ Fax No: _____ Cell phone:_____ Email: _____

NYS License No (Required): _____ NPI No _____ Date: _____

Practitioner's Signature: _____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS - FORMS CANNOT BE COMPLETED BY A RESIDENT Rev 3/23 PARENTS MUST SIGN PAGE 2 →

MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment Order Form | Office of School Health | School Year **2023–2024**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

PARENT/GUARDIAN READ, COMPLETE, AND SIGN: BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medical supplies, equipment and prescribed treatments being stored and given at school based on directions from my child's health care practitioner.
2. I understand that:
   - I must give the school nurse/school based health center (SBHC) provider my child's medical supplies, equipment and treatments.
   - **All supplies I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired supplies for my child's use during school days.**
     - Supplies, equipment and treatments should be labeled with my child's name and date of birth.
   - I must **immediately** tell the school nurse/SBHC provider about any change in my child's treatments or the health care practitioner's instructions.
   - The Office of School Health (OSH) and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this form, I authorize OSH to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The treatment instructions/orders on this form expire at the end of my child's school year, which may include the summer session, or when I give the school nurse a new form (whichever is earlier). When this medication order expires, I will give my child's school nurse/ SBHC provider a new MAF written by my child's health care practitioner.
   - This form represents my consent and request for the medical services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Section 504 Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication, or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

Per the New York State Education Department, nurses are not permitted to administer premixed medications and feedings. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.

FOR SELF-TREATMENT (INDEPENDENT STUDENTS ONLY)

- I certify/confirm that my child has been fully trained and can perform treatments on his or her own. I consent to my child carrying, storing and giving him or herself, the treatments prescribed on this form in school. I am responsible for giving my child these supplies and equipment labeled as described above. I am also responsible for monitoring my child's treatments, and for all results of my child's self-treatment in school. The school nurse/SBHC provider will confirm my child's ability to perform treatments on his/her own. I also agree to give the school clearly labeled "back up" equipment or supplies in the event that my child is unable to self-treat.

Student Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

SchoolATSDBN/Name: _____

Borough: _____ District: _____

Parent/Guardian's Email: _____ **Parent/Guardian's Address:** _____

Telephone Numbers: Daytime: _____ Home: _____ Cell Phone*: _____

Parent/Guardian's Name: _____ **Parent/Guardian's Signature:** _____

Date Signed: _____

Alternate Emergency Contact:

Name: _____ Relationship to Student: _____ Contact Number: _____

FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

OSIS Number: _____

Received by: Name: _____ Date: _____ Reviewed by: _____ 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: ☐ Clarified ☐ Modified

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

FOR PRINT USE ONLY