Attach student photo here

REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment 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 | ☐ Male ☐ Female

OSIS Number __ __ __ __ __ __ __ __ __

School (include ATSDBN/name, address and borough) | **DOE District** | **Grade** | **Class**

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.

☐ Clean Intermittent Catheterization Cath Size _____Fr.
☐ Central Venous Line
☐ G-Tube Feeding*: ☐ Bolus ☐ Pump ☐ Gravity Cath Size _____Fr.
☐ J-Tube Feeding*: ☐ Bolus ☐ Pump ☐ Gravity Cath Size _____Fr.
☐ Naso-Gastric Feeding* Cath Size _____Fr.
☐ Specialized/Non-Standard Feeding* Cath Size _____Fr.
☐ Feeding Tube replacement if dislodged - specify in area below
☐ Oral / Pharyngeal Suctioning Cath Size _____Fr.

☐ Tracheostomy Care Trach. Size _____.
☐ Trach. suctioning Cath. Size _____Fr.
☐ Trach replacement - specify in area below
☐ Oxygen Administration - specify in area below
☐ Pulse Oximetry monitoring
☐ Vagus Nerve Stimulator
☐ Other: _____

☐ Ostomy Care
☐ Chest Clapping
☐ Percussion
☐ Postural Drainage
☐ Dressing Change

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)*

[ ] **Practitioner's initials**

I attest student demonstrated the ability to self-administer the prescribed treatment effectively for school/field trips/school-sponsored events

1. Diagnosis: Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS)
☐ _ _ _ . _ _ _ ☐ _ _ _ . _ _ _ ☐ _ _ _ . _ _ _

Diagnosis is self- limited ☐ Yes ☐ No

2. Treatment required in school:

☐ Feeding: _____ _____ _____ _____ _____ _____
Formula Name | Concentration | Route | Amount/Rate | Duration | Frequency/specific time(s) of administration

*** Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. 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: _____ _____ ☐ _____ ☐ prn ☐ O2 Sat < _____% ☐ _____
Amount (L) | Route | Frequency/specific time(s) of administration | Specify Symptoms

☐ Other Treatment: _____ _____ ☐ _____ ☐ prn _____
Treatment Name | Route | Frequency/specific time(s) of administration | Specify Symptoms

☐ Additional Instructions or Treatment: _____

3. Conditions under which treatment should not be provided:

4. Possible side effects/adverse reactions to treatment:

5. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions, including dislodgement or blockage of tracheostomy or feeding tube:

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

7. Date(s) when treatment should be: Initiated __ __ / __ __ / __ __ __ __ Terminated __ __ / __ __ / __ __ __ __

Health Care Practitioner LAST NAME FIRST NAME Signature
Please Print and select one:
☐MD ☐DO ☐NP ☐PA

Address | Tel. No. (__ __ __) __ __ __ - __ __ __ __ | Fax No (__ __ __) __ __ __ - __ __ __ __

E-mail address | Cell phone (__ __ __) __ __ __ - __ __ __ __

NYS License No **(Required)** ___ ___ ___ ___ ___ ___ | NPI No. __ __ __ __ __ __ __ __ __ __ | Date __ __ / __ __ / __ __ __ __

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PARENT/GUARDIAN FILL BELOW

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 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 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 a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
   - 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 Student 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.

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 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.

Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __	School
School ATSDBN/Name			Borough Select Borough	District
Parent/Guardian's Name (Print)		SIGN HERE	**Parent/Guardian's Signature**	**Date Signed** __ __ / __ __ / __ __ __ __
Parent/Guardian's Email			**Parent/Guardian's Address**	

Telephone Numbers:

Daytime (__ __ __) __ __ __ - __ __ __ __ **Home** (__ __ __) __ __ __ - __ __ __ __ **Cell Phone*** (__ __ __) __ __ __ - __ __ __ __

Alternate Emergency Contact's Name	**Relationship to Student**	**Alternate Contact's Telephone Number** (__ __ __) __ __ __ - __ __ __ __

FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

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

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

FOR PRINT USE ONLY