Attach student photo here

GENERAL MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR DIABETES, SEIZURE, ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form I Office of School Health I 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: _____

OSIS Number: _____ Sex: ☐ Male ☐ Female

School (include name, number, address, and borough): _____ DOE District: _____ Grade: _____

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

☐ 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 during school, field trips, and school sponsored events - Practitioner's Initials: _____

In School Instructions

☐ Standing daily dose – at _____ and _____ **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/nurse-trained staff must administer

☐ 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 during school, field trips, and school sponsored events - Practitioner's Initials: _____

In School Instructions

☐ Standing daily dose – at _____ and _____ **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/nurse-trained staff must administer

☐ 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 during school, field trips, and school sponsored events - Practitioner's Initials: _____

In School Instructions

☐ Standing daily dose – at _____ and _____ **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) ☐ None

Health Care Practitioner Last Name:_____ First Name: _____ Signature: _____

Please select one: ☐ MD ☐ DO ☐ NP ☐ PA

Address: _____ E-mail address: _____

Tel. No: _____ FAX No: _____ 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

PARENTS MUST SIGN PAGE 2 →

GENERAL MEDICATION ADMINISTRATION FORM

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

PARENTS/GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. **I understand that:**
   - I must give the school nurse/school based health center (SBHC) my child's medicine and equipment.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box.** I will provide the school with current, unexpired medicine for my child's use during school days.
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I must **immediately** tell the school nurse/SBHC provider about any change in my child's medicine or the health care practitioner's instructions.
   - **No student is allowed to carry or give him or herself controlled substances.**
   - 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 medication administration form (MAF), OSH may 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 medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse/SBHC provider a new MAF (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 medication 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.

FOR SELF-ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself, the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse/SBHC provider will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

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

School (ATS DBN/Name): _____ Borough: _____ District: _____

Parent/Guardian Name (Print): _____ Parent/Guardian's Email: _____

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Address: _____

Telephone Numbers: Daytime: _____ Home_____ Cell Phone: _____

Alternate Emergency Contact:

Name: _____ Relationship to Student: _____ Phone Number:_____

For Office of School Health (OSH) Use Only

OSIS Number: _____ **Received by -** Name: _____ Date: _____

☐ 504 ☐IEP ☐ Other: _____ **Reviewed by -** Name: _____ Date: _____

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