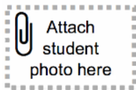

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2021–2022**

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: ____________

Sex: ☐ Male ☐ Female OSIS Number: __________ Weight: ___

School (include name, number, address, and borough):

DOE District: ____ Grade: ______ Class: _______

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergies: ☐ Allergy to: ______________ ☐ Allergy to: ______________ ☐ Allergy to: ______________ ☐ Allergy to: ______________

History of asthma? ☐ Yes (If yes, student has an increased risk for a severe reaction; complete the Asthma MAF for this student) ☐ No

History of anaphylaxis? ☐ Yes Date: ________________ ☐ No

If yes, system affected ☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic

Treatment: ______________________________________ Date: ____________________

Does this student have the ability to:

Self-Manage (See 'Student Skill Level' below)	☐ Yes	☐ No
Recognize signs of allergic reactions	☐ Yes	☐ No
Recognize and avoid allergens independently	☐ Yes	☐ No

Select In-School Medications

SEVERE REACTION

A. Immediately administer epinephrine ordered below, then call 911.

☐ 0.15 mg ☐ 0.3 mg

Give intramuscularly in the anterolateral thigh for any of the following signs/symptoms (retractable devices preferred) :

- 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 signs/symptoms after a sting or eating these foods, give epinephrine.

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

☐ If this box is checked, give antihistamine after epinephrine administration (order antihistamine below)

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

☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events - Practitioner's Initials: ____________

MILD REACTION

A. Give antihistamine: Name: ______________________________ Preparation/Concentration: ______________Dose: ________ Route:________

Frequency: ☐ Q4 hours or ☐ Q6 hours as needed for any of the following signs/symptoms:

- Itchy nose, sneezing, itchy mouth
- A few hives or mildly itchy skin
- Mild stomach nausea or discomfort
- Other:______________

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

☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events - Practitioner's Initials: ____________

OTHER MEDICATION

- 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):

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

Home Medications (include over the counter) ☐ None

Health Care Practitioner

Last Name (Print):______________________ First Name (Print): ______________________ Signature: ______________________

NYS License # (Required): ______________ NPI #: ______________ **Please check one:** ☐ MD ☐ DO ☐ NP ☐ PA Date: ________________

Address: ____ E-mail address: ______________________________

Tel: ____________________________ FAX: ____________________________ Cell Phone: ____________________________

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2021–2022

Please return to school nurse. 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 my child's medicine and equipment. I will try to give the school epinephrine pens with retractable needles.
   - **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 certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma or epinephrine medicines are not available.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
   - 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), I authorize the Office of School Health (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 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 a new MAF (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 allergy 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 for 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.

SELF-ADMINISTRATION OF MEDICATION (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 boxesas 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 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.
- I consent to the school nurse or trained school staff giving my child epinephrine if my child is temporarily unable to carry and give him or herself medicine.

NOTE: If you decide to use stock, you must send your child's epinephrine, asthma inhaler and other approved self-administered medications on a school trip day and/or after school programs in order that he/she has it available. Stock medications are only for use by OSH staff in school only.

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: ____

Parent/Guardian Cell Phone: ______________________ Other Phone ______________________

Other Emergency Contact Name/Relationship: ____

Other Emergency Contact Phone: ______________

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 per Office of School Health after consultation with prescribing practitioner: ☐ Clarified ☐ Modified