

過敏/過敏反應症的藥物施用表

提供者醫療手續執行表 | 學校健康辦公室 | **2019-2020 學年**
請交還給學校護士。2019年5月31日之後遞交的表格可能延遲受理新學年服務的申請。

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

保健專業人員填寫以下內容

Specify Allergy <input type="checkbox"/> Allergy to	Specify Allergy <input type="checkbox"/> Allergy to	Specify Allergy <input type="checkbox"/> Allergy to
History of asthma? <input type="checkbox"/> Yes (If yes, student has an increased risk for a severe reaction) <input type="checkbox"/> No	Does this student have the ability to: Self-Manage (See 'Student Skill Level' below) <input type="checkbox"/> Yes <input type="checkbox"/> No	
History of anaphylaxis? <input type="checkbox"/> Yes Date ___/___/____ <input type="checkbox"/> No	Recognize signs of allergic reaction <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, system affected <input type="checkbox"/> Respiratory <input type="checkbox"/> Skin <input type="checkbox"/> GI <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Neurologic	Recognize/avoid allergens independently <input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment	Date ___/___/____	

Select In School Medications

1. SEVERE REACTION

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

- Epinephrine** Auto-Injector 0.15 mg
 - Epinephrine** Auto-Injector 0.3 mg (retractable devices preferred) intramuscularly into the anterolateral of thigh for **any** of the following symptoms:
 - Shortness of breath, wheezing, or coughing
 - Fainting or dizziness
 - Lip or tongue swelling that bothers breathing
 - Pale or bluish skin color
 - Tight or hoarse throat
 - Vomiting or diarrhea (if severe or combined with other symptoms)
 - Weak pulse
 - Trouble breathing or swallowing
 - Feeling of doom, confusion, altered consciousness or agitation
 - Many hives or redness over body
 - 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 symptoms after a sting or eating these foods, **give epinephrine.**

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

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

Independent Student: student is self-carry/self-administer

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

Practitioner's
Initials

2. MILD REACTION

A. Give antihistamine: Name: _____ Preparation/Concentration: _____ Dose: _____ Route: _____

- Frequency: Q4 hours or Q6 hours as needed for **any** of the following symptoms:
- Itchy nose, sneezing, itchy mouth
 - A few hives or mildly itchy skin
 - Mild stomach nausea or discomfort
 - Other: _____

B. If symptoms of severe allergy/anaphylaxis develop, or if more than one symptom from each system is present, use epinephrine and call 911.

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

Independent Student: student is self-carry/self-administer

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

Practitioner's
Initials

3. 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 for school/fieldtrips/school sponsored events.

Practitioner's
Initials

Home Medications (include over-the counter)

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

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家長/監護人填寫以下內容

我在下面簽名，表示我同意如下：

- 我同意，學校保存我子女的醫藥並根據我子女的保健專業人員的說明給藥。我也同意，我子女的醫藥所需的任何器材都在學校裏儲存和使用。
- 我理解：
 - 我必須把我子女的醫藥和器材交給學校護士。我將儘量給學校有伸縮針頭的腎上腺素注射器 (Iepinephrine pens with retractable needles)。
 - 我所給予學校的所有處方和非處方藥物都必須是新的、未曾打開過並裝在其原封瓶子或盒子裏。我將給學校提供供我子女在上學日內使用的當前、未過期的醫藥用品。
 - 處方藥物必須在其盒子或瓶子上有本來的藥房標籤。標籤必須包括：1) 我子女的姓名，2) 藥房名稱和電話號碼，3) 我子女的保健專業人員姓名，4) 日期，5) 重配次數，6) 藥物名稱，7) 劑量，8) 何時用藥，9) 如何用藥以及 10) 任何其他說明。
 - 我謹此證明/確認，我已諮詢我子女的保健專業人員，並且我同意學校健康辦公室在萬一我子女沒有哮喘藥物或腎上腺素藥物之際可以給我子女施用儲存的藥物。
 - 如果我子女的藥物發生任何變化或者保健專業人員的說明有任何變化，我必須立即告知學校護士。
 - 涉及到給我子女提供上述健康服務的學校健康辦公室 (OSH) 及其代理人員依賴於本表資訊的精確度。
 - 我在這一「藥物施用表」(Medication Administration Form, 簡稱 MAF) 上簽名，表示授權學校健康辦公室 (Office of School Health, 簡稱 OSH) 為我子女提供健康服務。這些服務可以包括 (但不限於) 由一名 OSH 辦公室保健專業人員或護士所執行的一次臨床評估或一次體檢。
 - 這份 MAF 表的醫療執行手續的過期時間是我子女的學年結束 (這可能包括暑期班) 或者當我交給學校護士一份新的 MAF (取兩者中較早的那個時間)。
 - 這份表格代表我對本表所說明的過敏服務的同意和要求。這並非 OSH 提供所要求的服務的協議。如果 OSH 決定提供這些服務，我子女可能還需要一份「學生特別照顧計劃」(Student Accommodation Plan)。這份計劃將由學校填寫。
 - 為著給我子女提供護理或治療的目的，OSH 可以獲取該辦公室認為有關我子女的醫療狀況、藥物和治療而需要的任何其他資訊。OSH 可以從任何為我子女提供健康服務的保健專業人員、護士或藥劑師那裏獲取該資訊。

自己用藥 (僅適用於能自己獨立用藥的學生)：

- 我證明/確認，我子女已得到完全的訓練並能夠自行用藥。我同意，我子女在學校裏自己攜帶、儲存本表所開具的藥物並將自己用藥。我負責根據上述說明把瓶子或盒子裏的藥物交給我子女。我也負責監督我子女在學校裏的藥物使用情況及其對這一藥物使用所產生的任何結果。學校護士將確認我子女擁有攜帶和自行用藥的能力。我也同意交給學校「備用」藥物 (裝在清楚地標示的盒子或瓶子裏)。
- 我同意，如果我的子女臨時不能帶藥物或者不能給自己用藥，學校護士或受過訓練的職員可以給我子女用藥。
- 我同意，如果我子女臨時不能攜帶或自行用藥，學校護士或經過訓練的學校員工可以給我子女施用藥物。

說明：如果您決定使用儲存的藥物，則您必須在您子女參加學校外出參觀的日子以及/或者課後計劃時讓子女帶上 epinephrine、哮喘吸入器以及其他獲准的自我施用藥物，以備您子女使用。儲存的藥物只是由 OSH 員工在學校使用。

學生 姓	名	中間名	出生日期 ___/___/_____	學校
學校 ATSDBN/名稱			行政區	學區
家長/監護人姓名 (清楚書寫)			家長/監護人簽名	簽名日期 ___/___/_____
家長/監護人電子郵箱			家長/監護人地址	
電話號碼 日間 (____) _____ - _____		住宅 (____) _____ - _____	手機* (____) _____ - _____	
其他緊急聯絡人姓名		與學生的關係	聯絡電話(____) _____ - _____	

For Office of School Health (OSH) Use Only (僅由學校健康辦公室填寫)

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