Kole foto elèv la la a

# FÒM POU BAY MEDIKAMAN KONT ALÈJI/ANAPHYLAXIS

Fòm demand medikaman pou founisè | Biwo sante lekòl | Ane lekòl **2020-2021**

**Tanpri voye l tounen ba enfimyè lekòl la. Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la.**

| Siyati **elèv la** | Non li | Inisyal li | **Dat nesans elèv la** __ __ / __ __ / __ __ __ __ MM DD YYYY | ☐ Gason ☐ Fi |
|---|---|---|---|---|

**Nimewo OSIS** __ __ __ __ __ __ __ __ __ __ **Pwa** ----------(kg)

| **Lekòl (mete ATSDBN) non, nimewo, adrès ak borough** | **Distri DOE** | **Klas** | **Nivo Klas** |
|---|---|---|---|
| | | | |

## HEALTH CARE PRACTITIONERS COMPLETE BELOW

| **Specify Allergy** | **Specify Allergy** | **Specify Allergy** |
|---|---|---|
| ☐ Allergy to | ☐ Allergy to | ☐ Allergy to |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **History of asthma?** | ☐ Yes (***If yes, student has an increased risk for a severe reaction)*** | | | | | ☐ No | **Does this student have the ability to:** | |
| **History of anaphylaxis?** | ☐ Yes Date __ __ / __ __ / __ __ __ __ | | | | | ☐ No | Self-Manage *(See 'Student Skill Level' below)* | ☐ Yes ☐ No |
| If yes, system affected | ☐ Respiratory | ☐ Skin | ☐ GI | ☐ Cardiovascular | ☐ Neurologic | | Recognize signs of allergic reactions | ☐ Yes ☐ No |
| Treatment | | | Date __ __ / __ __ / __ __ __ __ | | | | Recognize/avoid allergens independently | ☐ Yes ☐ No |

### Select In School Medications

**1. 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 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 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)

**C.** 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 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

*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 | | | |
| NYS License # **(Required)** | NPI # __ __ __ __ __ __ __ __ __ __ | Tel. (__ __ __) __ __ __ - __ __ __ __ | Fax. (__ __ __) __ __ __ - __ __ __ __ |

# FÒM POU BAY MEDIKAMAN KONT ALÈJI/ANAPHYLAXIS

Provider Medication Order Form | Office of School Health | School Year 2020-2021

**Tanpri voye l tounen ba enfimyè lekòl la. Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la.**

## PARAN/RESPONSAB RANPLI PATI PI BA A

### LÈ M SIYEN PI BA, MWEN DAKÒ AVÈK BAGAY SA YO:

1. Mwen dakò pou yo konsève medikaman pitit mwen ak ba li yo nan lekòl la dapre eksplikasyon doktè pitit mwen an bay. Mwen dakò tou pou yo konsève nenpòt ekipman yo bezwen pou yo ka konsève medikaman pitit mwen an ak itilize l nan lekòl la.
2. Mwen konprann ke:
   - Mwen dwe bay enfimyè lekòl la medikaman ak ekipman pitit mwen an. M ap eseye bay lekòl la epinephrine pens ansanm ak egwi retraktab yo.
   - **Tout medikaman ak preskripsyon ak tout medikaman "ki vann san preksripsyon(over-the-counter)" fèt pou nèf, kachte nan bwat oswa boutèt orijinal la. M ap bay lekòl la medikaman ki resan, ki pa ekspire pou pitit mwen itilize pandan jounen lekòl la..**
     - Medikaman ki vann ak preskripsyon yo fèt pou gen etikèt orijinal famasi a sou bwat la oswa sou boutèy la. Etikèt la dwe gen ladan: 1) non pitit mwen an, 2) non ak nimewo telefòn famasi a, 3) non doktè pitit mwen an, 4) dat, 5) kantite rechaj(refills), 6) non medikaman an, 7) dozaj, 8) lè pou li pran l, 9)kòman pou li pran medikaman an ak 10) nenpòt lòt eksplikasyon.
   - Mwen sètifye/konfime mwen pale avèk doktè pitit mwen an epi mwen bay konsantman m pou OSH ba pitit mwen an medikaman ki disponib nan lekòl la nan ka kote medikaman kont opresyon medikaman epinephrine pa ta disponib.
   - Mwen dwe di enfimyè lekòl la **imedyatman** nenpòt chanjman ki genyen nan medikaman pitit mwen an oswa nan eksplikasyon doktè k ap trete l.
   - OSH ak ajan li ki patisipe nan ofri pitit mwen an sèvis sante ki pi wo yo konte sou presizyon ki nan enfòmasyon ki sou fòm sa a.
   - Lè m siyen fòm pou bay medikaman sa a (medication administration form, MAF) sa a, mwen otorize Biwo sante lekòl (Office of School Health, OSH) pou bay pitit mwen an sèvis sante. Sèvis sa yo ka genyen ladan pami lòt, yon evalyasyon klinik oswa yon konsiltasyon medikal yon doktè oswa yon enfimyè OSH fè.
   - Lòd pou bay medikaman ki sou fòm MAF sa a ekspire nan fen ane lekòl pitit mwen an, ki ka gen ladan tou sesyon ete, oswa lè mwen bay enfimyè lekòl la yon nouvo fòm MAF(kèlkeswa sa ki rive avan an). Lè preskripsyon medikaman sa a ekspire, m ap bay enfimyè lekòl pitit mwen an yon nouvo fòm MAF ke doktè pitit mwen an ap ekri. OSH will not need my signature for future MAFs.
   - Fòm sa a reprezante konsantman m pou sèvis alèji yo dekri nan fòm sa a. se pa yon akò OSH genyen pou li bay sèvis ou mande a. Si OSH deside bay sèvis sa yo, pitit mwen an bezwen tou yon Plan akomodasyon pou elèv. Se lekòl la k ap ranpli plan sa a.
   - Nan objektif pou bay pitit mwen an swen oswa tretman, OSH ka gen nenpòt lòt enfòmasyon yo panse ki nesesè sou pwoblèm medikal pitit mwen an, medikaman l ap pran oswa tertman l suiv. OSH ka pran enfòmasyon sa a nan men nenpòt doktè, enfimyè oswa famasyen ki bay pitit mwen an sèvis.

### POU ELÈV KI KA PRAN MEDIKAMN POUKONT YO (ELÈV KI ENDEPANDAN SÈLMAN)

- Mwen sètifye/konfime pitit mwen an resevwa bon jan trening epi li kapab pran medikaman poukont li. Mwen dakò pou pitit mwen an pote, konsève ak pran poukontli medikaman yo preskri nan fòm sa a nan lekòl la. Mwen gen responsablite pou bay pitit mwen an medikaman sa a nan boutèy oswa nan bwat yo jan yo dekri sa pi wo a. Mwen gen responsablite pou m sipèvize itilizasyon medikaman pitit mwen an ak pou tout konsekans ki genyen nan itilizasyon medikaman pitit mwen an pran nan lekòl la. Enfimyè lekòl la pral konfime kapasite pitit mwen an pou l pote ak pran medikaman yo poukont li. Mwen dakò tou pou m bay lekòl la medikaman "an rezèv" nan yon bwat oswa boutèy ki gen etikèt byen klè sou li.
- Mwen dakò pou enfimyè lekòl la oswa manm estaf ki resevwa trening bay pitit mwen an epinephrine si li pa kapab pote ak pran yo poukont li pou yon ti tan.

**SONJE: <u>Si ou chwazi pou itilize medikaman ki nan depo lekòl la, ou dwe voye pitit ou a avèk epinephrine, ponp opresyon ak lòt medikaman ki apwouve li gen pou pran poukont li nan pwomnad lekòl la</u> ak/oswa nan pwogram aprelekòl pou li ka genyen li disponib. Medikaman ki nan depo yo se sèlman estaf OSH ki nan lekòl la ki pou itilize yo.**

| Siyati elèv la | Non elèv la | Inisyal | Dat nesans elèv la __ __ / __ __ / __ __ __ __ | Lekòl |
|---|---|---|---|---|
| **Non/ATSDBN lekòl la** | | | Borough | Distri |
| Non Paran/Responsab (enprime) | | **SIYEN LA** | **Siyati paran/responsab** | **Dat siyati a** __ __ / __ __ / __ __ __ __ |
| **Imèl paran/responsab la** | | | **Adrès Paran/Responsab** | |

**Nimewo telefòn**: **Lajounen** ( __ __ __ ) __ __ __ - __ ___ **Lakay** ( __ __ __ ) __ __ __ - __ __ __ __ **Selilè*** ( __ __ __ ) __ __ __ - __ __ __ __

**Non lòt moun pou kontakte nan ka ijans** **Lyen avèk elèv la**

**Nimewo Telefòn lòt moun pou nou kontakte a** ( __ __ __ ) __ __ __ - __ __ __ __

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

* *Ou pa dwe voye enfòmasyon konfidansyèl pa imèl

POU ITILIZASYON ENPRIMRI SÈLMAN