

DIABETES MEDICATION ADMINISTRATION FORM

Provider Medication Order Form – Office of School Health – School Year **2018-2019**

DUE: JULY 15th. Forms submitted after July 15th may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945.

PARENTS/GUARDIANS FILL BELOW


By signing below, I agree to the following:

1. I consent to the nurse giving my child's prescribed medicine, and my child's school checking my child's blood sugar, and treating my child's low blood sugar based on my child's health care practitioner's directions. The school may perform these actions on school grounds or during school trips.
2. I also consent to any equipment needed for my child's medicine being stored and used at school.
3. I understand that:
 - I must give the school nurse my child's medicine, snacks, and equipment. I will try to give the school safety lancets and other safety needle devices and supplies to check my child's blood sugar levels and give insulin.
 - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.**
 - 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 about any change in my child's medicine 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 Medication Administration Form (MAF), OSH may provide health services to my child. These services may include 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).
 - If this medication order expires, and my child's health care practitioner does not write a new MAF, an OSH health care practitioner may fill out a new diabetes MAF for my child. **OSH will not need my signature to write future diabetes MAFs.**
 - OSH and the Department of Education (DOE) are responsible for making sure that my child can safely test his or her blood sugar in the medical room and any school location.
 - This form represents my consent and request for the diabetes 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.
 - 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.
 - If the school nurse is unavailable, I may be notified to come to school to give my child medicine.

FOR SELF-ADMINISTRATION OF MEDICINE:

- 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 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 medicine if my child is temporarily unable to carry and give him or herself medicine.

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
Print Parent/Guardian's Name			Parent/Guardian's Signature	
			SIGN HERE 	
Date Signed ___ / ___ / _____	Parent/Guardian's Email	Parent/Guardian's Address		
Telephone Numbers: Daytime (____) _____ - _____ Home (____) _____ - _____ Cell Phone (____) _____ - _____				
Alternate Emergency Contact's Name			Contact Telephone Number (____) _____ - _____	

For Office of School Health Use Only

OSIS Number:	<input type="checkbox"/> 504	<input type="checkbox"/> IEP	<input type="checkbox"/> Other
Received by: Name	Date ___ / ___ / _____	Reviewed by: Name	Date ___ / ___ / _____
Services provided by:	<input type="checkbox"/> Nurse/NP	<input type="checkbox"/> OSH Public Health Advisor (For supervised students only)	<input type="checkbox"/> School Based Health Center
Signature and Title (RN OR MD/DO/NP):			
Revisions per OSH after consultation with prescribing health care practitioner	<input type="checkbox"/> Modified	<input type="checkbox"/> Not Modified	