

GENERAL MEDICATION ADMINISTRATION FORM THIS FORM SHOULD NOT BE USED FOR SEIZURE, ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form | Office of School Health | School Year 2020–2021 e return to school nurse. Forms submitted after June 1st may delay processing for new school

tudent Last Name	First Name	Middle	Date of birth//_		□ Male □ Female
SIS Number					<u> </u>
chool (include ATSDB	N/name, address and borough)		DOE District	Grade	Class
	HEALTH CA	RE PRACTITIO	NERS COMPLETE BELOV	V	
Medication: Preparation/Concentration Dose: Student Skill Level (Sample of Supervised Student Independent Student Independent Student Initial below for Incomplete of Supervised Student Student Student Student Student Student Skill Level (Sample of Supervised Student Independent Student Independent Student Independent Student Stud	Route: Select the most appropriate option) Student: nurse must administer me at: student self-administers, under a ent: student is self-carry / self-admir lependent (Not allowed for controlle I attest student demonstrated ability the prescribed medication effectively fieldtrips / school sponsored events. ICD-10 Code:	dication dult supervision dister ed substances) to self-administer of or school / dication dult supervision dister ed substances) to self-administer	□ PRN specify sign □ Time interval: minutes or □ If no improvement, repeat in maximum of times. Conditions under which medicatio In School Instructions □ Standing daily dose: at : □ PRN	AM / PM and AND/OR as, symptoms, or situat hours as neede minutes or h n should not be given: AM / PM and AND/OR accify signs, symptoms, or situat hours as neede minutes or h	ions ed. ours for a : AM / PM ations ed.
Medication:	Generic and/or Brand Name attion:	dication dult supervision nister ed substances) to self-administer of or school /	In School Instructions ☐ Standing daily dose: at : am / pm and : AM / P 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:		
	номе	MEDICATIONS (in	clude over-the counter)		
Health Care Practition Please print and circle on MD DO NP Address		FIRST	Signature	Date	//)
NYS License # (Require	NPI #		Tel. ()	Fax. (_)

GENERAL MEDICATION ADMINISTRATION FORM

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

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Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

PARENTS/GUARDIANS FILL BELOW

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.
- 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 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 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 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 Student 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 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 o	ff-site school activities.		
Student Last Name	First Name	MI	Date of birth / / /		
School ATSDBN/Name		Borough	District		
Print Parent/Guardian's Name	SIGN HER	Parent/Guardian's Sig	nature Date Signed		
Parent/Guardian's Email	,	Parent/Guardian's Address			
Telephone Numbers: Daytime ()	Home (
Alternate Emergency Contact's Name	Relationship to Student	Contact Telephone Numb	per ()		

For Office of School Health (OSH) Use Only **OSIS Number:** Reviewed by: Name Received by: Name Date ___/___ 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 Date School Notified & Form Sent to DOE Liaison __ / _ _ / _ _ _ _ Signature and Title (RN OR SMD): ☐ Modified Revisions as per OSH contact with prescribing health care practitioner □ Not Modified