**GENERAL MEDICATION ADMINISTRATION FORM**

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

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 MM/DD/YYYY | Gender [ ] Male [ ] Female

OSIS Number __ __ __ __ __ __ __ __ __ __

School (include ATSDBN/name, address and borough) | DOE District | Grade | Class

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### HEALTH CARE PRACTITIONERS COMPLETE BELOW

#### 1. Diagnosis: ____________________ ICD-10 Code: [ ] _ _ _

Medication: ____________________

Generic and/or Brand Name

Preparation/Concentration: 

Dose: 

Route:

Student Skill Level (Select the most appropriate option):

- Nurse-Dependent Student: nurse must administer medication
- Supervised Student: student self-administers, under adult supervision
- Independent Student: student is self-care / self-administer

Initial below for Independent (Not allowed for controlled substances)

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

Practitioner’s Initials

In School Instructions

- Standing daily dose: at _ : _ AM / PM and _ : _ AM / PM
- 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:

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#### 2. Diagnosis: ____________________ ICD-10 Code: [ ] _ _ _

Medication: ____________________

Generic and/or Brand Name

Preparation/Concentration: 

Dose: 

Route:

Student Skill Level (Select the most appropriate option):

- Nurse-Dependent Student: nurse must administer medication
- Supervised Student: student self-administers, under adult supervision
- Independent Student: student is self-care / self-administer

Initial below for Independent (Not allowed for controlled substances)

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

Practitioner’s Initials

In School Instructions

- Standing daily dose: at _ : _ AM / PM and _ : _ AM / PM
- 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:

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#### 3. Diagnosis: ____________________ ICD-10 Code: [ ] _ _ _

Medication: ____________________

Generic and/or Brand Name

Preparation/Concentration: 

Dose: 

Route:

Student Skill Level (Select the most appropriate option):

- Nurse-Dependent Student: nurse must administer medication
- Supervised Student: student self-administers, under adult supervision
- Independent Student: student is self-care / self-administer

Initial below for Independent (Not allowed for controlled substances)

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

Practitioner’s Initials

In School Instructions

- Standing daily dose: at _ : _ AM / PM and _ : _ AM / PM
- 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:

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**HOME MEDICATIONS (include over-the-counter)**

**Health Care Practitioner Name**

(Please print and circle one: MD, DO, NP, PA)

Signature

Date MM/DD/YYYY

Address

Tel. (______)______-______

Fax. (______)______-______

NYS License # (Required)

NPI #
GENERAL MEDICATION ADMINISTRATION FORM

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

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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/confirrn 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 off-site school activities.

Student Last Name  First Name  MI  Date of birth __ __ / __ __ / __ __ __ __

School ATSDBN/Name  Borough  District

Print Parent/Guardian’s Name  Parent/Guardian’s Signature  Date Signed  __ __ / __ __ / __ __ __ __

Parent/Guardian’s Email

Telephone Numbers:  Daytime ( __ __ __ ) __ __ __ __  Home ( __ __ __ ) __ __ __ __  Cell Phone ( __ __ __ ) __ __ __ __

Alternate Emergency Contact’s Name  Relationship to Student  Contact Telephone Number ( __ __ __ ) __ __ __ __

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

*Confidential Information should not be sent by email