Attach student photo here

MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS

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.

Student Last Name First Name Middle | **Date of birth** _ _ / _ _ / _ _ _ _ (MM DD YYYY) | ☐ Male ☐ Female

OSIS Number _ _ _ _ _ _ _ _ _ _

School (include name, number, address and borough) | **DOE District** | **Grade** | **Class**

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-carry / self-administer *(NOT ALLOWED FOR CONTROLLED SUBSTANCES)*

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

In School Instructions

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

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:

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-carry / self-administer *(NOT ALLOWED FOR CONTROLLED SUBSTANCES)*

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

In School Instructions

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

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:

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-carry / self-administer *(NOT ALLOWED FOR CONTROLLED SUBSTANCES)*

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

In School Instructions

☐ Standing daily dose: at _ _: _ _ am / pm and _ _: _ _ AM / PM

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:

HOME Medications (include over-the counter)

____

____

Health Care Practitioner (Please Print) LAST NAME FIRST NAME | Signature

Address | Tel. No. (_ _ _) _ _ _- _ _ _ _ | Fax. No (_ _ _) _ _ _ - _ _ _ _

E-mail address | Cell phone (_ _ _) _ _ _ - _ _ _ _

NYS License No **(Required)** _ _ - _ _ _ _ _ _ | NPI No. _ _ _ _ _ _ _ _ _ _ | Date _ _ / _ _ / _ _ _ _

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 ➔

藥物施用表

本表不應用於哮喘或過敏施藥.

提供者醫療手續執行表 | 學校健康辦公室 | 2018-2019 學年

截止日期：7 月 15 日。7 月 15 日之後遞交的表格可能延遲受理新學年服務的申請。

家長/監護人填妥以下內容。

在下面簽名，則表示我同意：

1. 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葯。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。
2. 我理解：
   - 我必須把我子女的醫藥和器材交給學校護士。
   - **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。**我將給子女另外再獲取一份藥物，供其在不上學時或在參加學校旅行時使用。
     - 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) 任何其它說明。
   - 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。
   - **學生不得攜帶或自我施用控制要藥物.**
   - 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」（MAF）上簽名，則學校健康辦公室（OSH）可以為我子女提供健康服務。這些服務可以包括由一名 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醫療服務的同意和要求。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。
   - OSH 可以獲取該辦公室認爲有關我子女的醫療狀況、藥物和治療而需要的任何其它資訊。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。
   - 如果學校護士不在，我可能會被通知前來學校為子女給藥。

自己用藥：

- 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：最好是您在學校外出參觀的日子和在校外進行學校活動時給子女帶上藥物和器材。

學生姓氏 名字 MI	出生日期	學校
清楚填寫家長/監護人的姓名 在此簽名	**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 住家	手機	
其他緊急聯絡人姓名	**聯絡電話號碼**	

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	

*請不要使用電子郵件發送保密資訊