Kole foto elèv la la a

DEMANND POU TRETMAN DOKTÈ REKÒMANDE (SE PA POU BAY MEDIKAMAN)

Fòm demand tretman pou founisè | Biwo sante lekòl | Ane lekòl **2019–2020**

Tanpri voye l tounen ba enfimyè lekòl la. Fòm yo resevwa apre 31 me ka retade pwosesis la pou nouvo ane lekòl la.

Student Last Name	First Name	Middle	**Date of birth** __ __ / __ __/ __ __ __ __ M M D D Y Y Y Y	☐ Male ☐ Female
OSIS Number __ __ __ __ __ __ __ __ __				
School (include ATSDBN/name, address and borough)			**DOE District**	**Grade** / **Class**

AJAN MEDIKAL, RANPLI PI BA A

ONE ORDER PER FORM (make copies of this from for additional orders). Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization.

- ☐ Clean Intermittent Catheterization Cath Size _____Fr.
- ☐ Central Venous Line
- ☐ G-Tube Feeding*: ☐ Bolus ☐ Pump ☐ Gravity Cath Size _____Fr.
- ☐ J-Tube Feeding*: ☐ Bolus ☐ Pump ☐ Gravity Cath Size _____Fr.
- ☐ Naso-Gastric Feeding* Cath Size _____Fr.
- ☐ Specialized/Non-Standard Feeding* Cath Size _____Fr.
- ☐ Feeding Tube replacement if dislodged - specify in area below
- ☐ Oral / Pharyngeal Suctioning Cath Size _____Fr.
- ☐ Tracheostomy Care Trach. Size _____.
- ☐ Trach. suctioning Cath. Size _____Fr.
- ☐ Trach replacement - specify in area below
- ☐ Oxygen Administration - specify in area below
- ☐ Pulse Oximetry monitoring
- ☐ Vagus Nerve Stimulator
- ☐ Other: _____
- ☐ Ostomy Care
- ☐ Chest Clapping
- ☐ Percussion
- ☐ Postural Drainage
- ☐ Dressing Change

Student will also require treatment: ☐ during transport ☐ on school-sponsored trips ☐ during afterschool programs

Student Skill Level *(Select the most appropriate option)***:**

1. Nurse-Dependent Student: nurse must administer treatment
2. Supervised Student: student self-treats under adult supervision
3. Independent Student: student is self-carry/self-treat *(initial below)*

☐ **Practitioner's initials** I attest student demonstrated the ability to self-administer the prescribed treatment effectively for school/field trips/school-sponsored events

1. Diagnosis: Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS)

☐ _ _ _ . _ _ _ ☐ _ _ _ . _ _ _ ☐ _ _ _ . _ _ _

Diagnosis is self- limited ☐ Yes ☐ No

2. Treatment required in school:

- Feeding: _____ _____ _____ _____ _____ _____
  Formula Name / Concentration / Route / Amount/Rate / Duration / Frequency/specific time(s) of administration

*** Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.**

☐ Flush with ____ mL _____ before feeding

- Oxygen administration: _____ _____ ☐ _____ ☐ prn ☐ O2 Sat < _____% ☐ _____
  Amount (L) / Route / Frequency/specific time(s) of administration / Specify Symptoms

☐ Other Treatment: _____ _____ ☐_____ ☐ prn _____
Treatment Name / Route / Frequency/specific time(s) of administration / Specify Symptoms

☐ Additional Instructions or Treatment:

3. Conditions under which treatment should not be provided:

4. Possible side effects/adverse reactions to treatment:

5. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions, including dislodgement or blockage of tracheostomy or feeding tube:

6. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:

7. Date(s) when treatment should be: Initiated __ __ / __ __ / __ __ __ __ Terminated __ __ / __ __ / __ __ __ __

Health Care Practitioner LAST NAME (**Please Print and circle one:** MD, DO, NP, PA)	FIRST NAME	Signature
Address	Tel. No. (__ __ __) __ __ __ - __ __ __ __	Fax. No (__ __ __) __ __ __ - __ __ __ __
E-mail address	Cell phone (__ __ __) __ __ __ - __ __ __ __	
NYS License No **(Required)** __ __ - __ __ __ __ __ __ __ __	NPI No. __ __ __ __ __ __ __ __ __ __	Date __ __ / __ __ / __ __ __ __

DEMANND POU TRETMAN DOKTÈ REKÒMANDE (SE PA POU BAY MEDIKAMAN)

Fòm demand tretman pou founisè | Biwo sante lekòl | Ane lekòl **2019–2020**

DELÈ : 31 me: Fòm yo resevwa apre 31 me ka retade pwosesis la pou nouvo ane lekòl la.

PARAN/RESPONSAB, RANPLI 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/founisè swen sante pitit mwen an bay.
2. Mwen konprann ke:
   - Mwen dwe bay enfimyè lekòl la materyèl, ekipman ak tretman medikal pitit mwen an.
   - **Tout materyèl mwen bay lekòl la 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.**
     - Materyèl ekipman ak tretman yo dwe make ak non, dat nesans pitit mwen an sou yo.
   - Mwen dwe di enfimyè lekòl la **imedyatman** nenpòt chanjman ki genyen nan tretman pitit mwen an oswa nan eksplikasyon doktè/founisè k ap bay swen k ap trete l la.
   - Biwo sante nan lekòl(Office of School Health, 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 sa a, mwen otorize 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/eksplikasyon pou bay tretman ki sou fòm 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).
   - Fòm sa a reprezante konsantman m ak demand mwen fè pou sèvis medikal yo dekri sou fòm sa a. se pa yon akò OSH genyen pou li bay sèvis ou mande a. Si OSH deside ofri sèvis sa yo, pitit mwen an ka bezwen tou yon Plan Akomodasyon pou Elèv(Student Accommodation Plan). 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 fè tretman yo poukont li. Mwen dakò pou pitit mwen an pote, konsève ak pran poukont li tretman yo preskri nan fòm sa a nan lekòl la. Mwen gen responsablite pou bay pitit mwen an materyèl ak ekipman sa yo ak etikèt, jan yo dekri sa pi wo a. Mwen gen responsablite tou pou m sipèvize tretman pitit mwen an ak pou tout konsekans ki genyen nan bay tèt li tretman poukont li. Enfimyè lekòl la pral konfime kapasite pitit mwen an pou l fè tretman poukont li. Mwen dakò tou pou bay lekòl la ekipman oswa materyèl "an rezèv" ki make byen klè sizoka pitit mwen an pa ka bay tèt li tretman poukont li.
- Mwen dakò pou enfimyè lekòl la oswa manm estaf ki resevwa trening bay pitit mwen an tretman pou yon ti tan si li pa kapab fè tretman poukont li.

Yo pa pèmèt ankò pou enfimyè bay medikaman oswa manje paran fin melanje. Enfimyè ka prepare ak melanje medikaman ak manje pou yo bay nan G-tube jan doktè fanmi an rekòmande l la.

Siyati elèv la / Non elèv la / Inisyal	Dat nesans elèv la __ __ / __ __ / __ __ __ __	Lekòl
Non/ATSDBN lekòl la	Borough	Distri
Non Paran/Responsab (enprime) **SIYEN LA A**	**Siyati paran/responsab**	**Dat ou siyen an** __ __ / __ __ / __ __ __ __
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** (__ __ __) __ __ __ - __ __ __ __

PLAS SA A REZÈVE POU OSH SÈLMAN:

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 nan yon imèl.

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