REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)
Provider Treatment 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.

One Order per Form (make copies of this form 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.

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

Evaluation of Need for Nurse Practitioner
□ Nurse-Dependent Student: nurse must administer treatment
□ Supervised Student: student self-administers under adult supervision
□ Independent Student: student is self-carry/self-administer:

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: __________________________

Oxygen administration: Amount (L) Route Frequency/specific time(s) of administration Specify Symptoms

Other Treatment: 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 (Please Print)

LAST NAME FIRST NAME Signature

Address

Tel. No. (______) _______ _______ Fax. No. (______) _______

E-mail address

Cell phone (______) _______ _______ _______

NYS License No (Required) _______ • _______ _______ _______

Date ______ / ______ / _______

Incomplete Practitioner Information will delay implementation of medication orders Forms cannot be completed by a resident
طلب تقديم علاج موصوف طبياً (غير دوائي)

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تاريخ الميلاد

المدرسة

اسم الوالد (الامر)(و/لا) الاسم الأول

إذا تم توجيه العلاج الذاتي، يرجى إدخال ملاحظة.

لا يجوز إرسال المعلومات السرية بواسطة البريد الإلكتروني.