Attach student photo here

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.

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**

HEALTHCARE PRACTITIONERS COMPLETE BELOW

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)*:

- □ 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: _____ _____ _____ _____ _____ _____
   Formula Name / Concentration / Route / Amount/Rate / Duration / Frequency/specific time(s) of administration
   *** Please note that parent prepared feeding or nurse prepared feeding, i.e. mixing powder with water, must receive approval from the Director/Deputy Director of Nursing**
   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 (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** Rev 3/18 **PARENTS MUST SIGN PAGE 2 ➔**

要求提供醫療處方治療的申請表（非藥物）

提供者治療要求表 | 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，根據我子女的保健專業人員的說明，學校保存和施用我子女的醫療用品、設備和處方治療法。
2. 我理解：
   - 我必須把我子女的醫療用品、設備和治療法交給學校護士。
   - **我所給予學校的所有用品都必須是新的、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用品，供其在不上學時或在參加學校旅行時使用。
     - 用品、設備和治療法都應標上我子女的姓名和出生日期。
   - 如果我子女的治療法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。
   - 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。
   - 我在這一表格上簽名，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。
   - 這份表格的治療說明/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施用治療法。

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施用治療法。我同意，我子女在學校裏自己攜帶、儲存本表所開具的治療法並將自己施用治療。我負責根據上述說明把這些用品和設備交給我子女。我也負責監督我子女在學校裏的治療法及我子女自我治療的所有結果。學校護士將確認我子女有自行施用治療的能力。我也同意，交給學校一份清楚地標著「備用」（back up）字樣的器材或用品，以備在我子女萬一不能自我施用治療時使用。
- 我同意，如果我子女臨時不能攜帶或自行治療，學校護士或經過訓練的學校員工可以給我子女施用治療。

家長準備的服用葯或護士準備的服用葯（即：用水混合藥粉類），都必須預先獲得護理主任/副主任的批准。

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**
家長/監護人地址		**簽名日期**

電話號碼日間	**住家**	**手機**
家長/監護人電子郵箱		
其他緊急聯絡人姓名		**其他聯絡人電話號碼**

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