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## ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2021–2022** Please return to school nurse. Forms submitted after June 1<sup>st</sup> may delay processing for new school year

	Please return to sci	iooi nurse. F	orms submitted	after June 1*	may de	lay pro	cessing for n	lew scr	lool year		
Student Last Name	First N	lame	Middle		D	ate of b	oirth/ MM_DD			□ Male □ Ferr	
OSIS Number			Weight	kg							
School (include ATSDBN/name, number, address and borough)					DOE Dis		District Grade		Class		
		HEALTH	CARE PRACT	ITIONERS CO	OMPLE	ETE BE	LOW				
Specify All	erav		Specify Allergy	I.		Specif	fy Allergy		Ì	Specify /	Alleray
□ Allergy to		□ Allergy to	<u> </u>	C	] Allergy		.j /		□ Allergy t		
History of asthma? Yes (If yes, student has an increased risk for a reaction; complete the Asthma MAF for this s				] No				s student ha	nt have the ability to:		
History of anaphylaxis?	□ Yes Date	//		C	] No		Self-Manage (See 'Studen	t Skill L		□ Yes	□ No
If yes, system affected	□ Respiratory	□ Skin [	∃ GI 🛛 □ Cardi	iovascular [	Neurol	ogic	Recognize signature reactions	-	•	□ Yes	□ No
Treatment			Da	ate/	_/		Recognize/avindependentl	/old alle y	rgens	□ Yes	🗆 No
<ul> <li>Shortness of br</li> <li>Pale or bluish s</li> <li>Weak pulse</li> <li>Many hives or r</li> <li>Other:</li> <li>If this box is che</li> <li>Even if child h</li> <li>B. If no improvement</li> <li>If this box is che</li> </ul> Student Skill Level (sele <ul> <li>Nurse-Dependent Stud</li> <li>Supervised Student: st</li> </ul> 2. MILD REACTION <ul> <li>A. Give antihistamine: I</li> <li>Frequency: Q 4 h</li> <li>Itchy nose, snee</li> </ul>	Irly in the anterolater eath, wheezing, or o kin color redness over body ecked, child has an o as <b>MILD signs/sym</b> to, or if signs/sympto ecked, give antihista ect the most appropri lent: nurse/nurse-trai udent self-administe	al thigh for <b>ar</b> oughing extremely sev <b>optoms after</b> ms recur, rep mine after ep ate option) ned staff mus rs, under adu	<ul> <li>by of the following</li> <li>Fainting or diz</li> <li>Tight or hoars</li> <li>Trouble breatly swallowing</li> <li>ere allergy to an instant of a sting or eating or eating or eating or eating interphrine administer</li> <li>ts administer</li> <li>ts upervision</li> <li>Prepara for any of the follow A few hives or mildly itchy skin</li> </ul>	signs/sympton zziness te throat hing or tinsect sting or t <b>g these foods</b> , nutes for maxim stration ( <i>order a</i> □ Independe <i>I attest student</i> + <i>medication effe</i> tion/Concentrat owing signs/sym • Mild stor	Lip     Lip     Von     Fee     follow     give epi     num of _     ntihistar     ent Stud     demonstri     trively du     ion: nptoms:     iaach nau	or tonguniting or tonguniting or of the second seco	ue swelling tha diarrhea (if se loom, confusion d(s): ne. mes (not to ex <i>low</i> ) dent is self-ca <i>ity to self-admin</i> <i>pol, field trips an</i> Dose: iscomfort	at bothe evere o con, alte cceed a rry/self- bister the d schoo	r combined red consciou total of 3 dc administer prescribed sponsored e Ro Other:	with othe usness or oses) vents.	Practitioner's Initials
Student Skill Level (sele In Nurse Dependent Stud Supervised Student: st	ent: nurse must adm	ninister	It supervision	□ Independe I attest student of medication effect	demonsti	rated abil	ity to self-admin	ister the	prescribed	events.	Practitioner's Initials
3. OTHER MEDICATI • Give Name: Route: Specify signs, symptoms, If no improvement, indica Conditions under which m	Frequency or situations: te instructions:	: Q	paration/Concentr □ minutes □		-	-	· · · · · · · · · · · · · · · · · · ·				
Student Skill Level (sele	ent: nurse must adm	ninister	It supervision Home Medicatio	l attest student medication effe	demonstr ctively du	rated abil Iring scho		nister the nd schoo	prescribed	events.	Practitioner's Initials
			nome metricalit		51-111 <del>5</del> 61	ounter)					
Health Care Practitione (Please print and circle on Address			FIRST		Signat	ture			ate/_ ax. ()	/	

NPI#

NYS License # (Required)

## ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2021–2022

Please return to school nurse. Forms submitted after June 1<sup>st</sup> may delay processing for new school year PARENTS/GUARDIANS: READ, COMPLETE, AND SIGN. 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. I will try to give the school epinephrine pens with retractable needles.
  - 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 certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma or epinephrine medicines are not available.
  - I must immediately tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
  - 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), I authorize the Office of School Health (OSH) to 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 allergy 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 for 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.

## SELF-ADMINISTRATION OF MEDICATION (INDEPENDENT STUDENTS ONLY):

- I certify/confirm 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.
- I consent to the school nurse or trained school staff giving my child epinephrine if my child is temporarily unable to carry and give him or herself medicine.

NOTE: If you decide to use stock, you must send your child's epinephrine, asthma inhaler and other approved self-administered medications on a school trip day and/or after school programs in order that he/she has it available. Stock medications are only for use by OSH staff in school only.

Student Last Name	First Name	MI	Date of birth / / /	School			
School ATSDBN/Name			Borough	District			
Parent/Guardian's Name (Print)		SIGN HER	Parent/Guardian's Signature	Date Signed			
Parent/Guardian's Email			Parent/Guardian's Address				
Telephone Numbers: Daytime ()	<sup>-</sup>	Home (	) Cell Phone	()			
Alternate Emergency Contact's Name	Relations	hip to Student	Contact Telephone Number (	_)			
<b>`</b>	I		I				

## For Office of School Health (OSH) Use Only

Received by: Name	Date//	Date//	
□ 504 □ IEP □ Other		Referred to School 504 Coordinato	<b>r</b> :□Yes □No
Services provided by:  □ Nurse/NP	□ OSH Public Health Ad	□ 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	g health care practitioner		Clarified Modified