

# ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM Provider Medication Order Form | Office of School Health | School Year 2021–2022

photo here	Provider Med ease return to schoo			ice of School H I <mark>after June 1<sup>st</sup> n</mark>				ar		
Student Last Name	First Name		Middle		Date of	Date of birth / /			□ Male □ Female	
OSIS Number	Number		Weightkg							
School (include ATSDBN/name, number, address and be			orough)		DOE	DOE District		Grade Class		
					<u> </u>		<u> </u>	,		
	I	HEALTH CAR	E PRACT	TITIONERS CO	MPLETE BE	LOW				
Specify Allergy Specify Allergy  □ Allergy to □ Allergy to						pecify Allergy Specify Allergy			Allergy	
☐ Allergy to	covoro	Allergy to	☐ Allergy to							
HISTORY OF ASTRIBLE?	udent)	No	Does this student have the ability to:							
History of anaphylaxis?	Yes Date/_	/	-		No	Self-Manage (See 'Studer	nt Skill Level' be	elow) □ Yes	s 🗆 No	
If yes, system affected	☐ Respiratory	Skin 🛮 GI	□ Card	iovascular 🛮	Neurologic	Recognize s reactions	igns of allergic	☐ Yes	s 🛮 No	
Treatment				ate/	/	Recognize/avoid allergens independently		☐ Yes	s 🗆 No	
			Select In	School Medic	ations	шаоронаона	.,			
<ul> <li>Shortness of brea</li> <li>Pale or bluish ski</li> <li>Weak pulse</li> <li>Many hives or red</li> <li>Other:</li> <li>If this box is check</li> <li>Even if child has</li> </ul>		phing Fa Tig Tro sw emely severe all	inting or diz ght or hoars buble breat vallowing lergy to an <b>g or eating</b>	zziness se throat hing or insect sting or th g these foods, g	<ul> <li>Lip or tong</li> <li>Vomiting o</li> <li>Feeling of</li> <li>e following fooive epinephri</li> </ul>	ue swelling the r diarrhea (if s doom, confusiond(s):	at bothers brea evere or comb on, altered cor	ined with othensciousness o		
	ked, give antihistamin						tocca a total o			
Student Skill Level (select the most appropriate option)				□ Independent Student: student is self-carry/self-administer						
<ul> <li>□ Nurse-Dependent Student: nurse/nurse-trained staff must ac</li> <li>□ Supervised Student: student self-administers, under adult su</li> </ul>				I attest student de medication effect	emonstrated ablively during sch	monstrated ability to self-administer the presc ely during school, field trips and school spon		bed ored events.	Practitioner's Initials	
2. MILD REACTION  A. Give antihistamine: Name: Preparation/Concentration: Dose: Route: Frequency: □ Q4 hours or □ Q6 hours as needed for any of the following signs/symptoms:  • Itchy nose, sneezing, itchy mouth										
☐ Supervised Student: student self-administers, under ad			ervision	I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored e					Practitioner's	
3. OTHER MEDICATIO  • Give Name: Route: Specify signs, symptoms, o If no improvement, indicate Conditions under which med  Student Skill Level (select	Frequency: Q r situations: instructions: dication should not be the most appropriate	e given:option)	I minutes □	ration: I hours as neede	d	: dent is self-ca		ister		
<ul> <li>□ Nurse-Dependent Student: nurse must administer</li> <li>□ Supervised Student: student self-administers, under adult supervision</li> </ul>				I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events.    Practitioner's Initials						
		Home	e Medicati	ons (include ove	r-the counter)		□ None	9		
Health Care Practitioner Name LAST FIRST (Please print and circle one: MD, DO, NP, PA) Address				Signature	Date/					
NYS License # (Required) NPI #					\					

### 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 1st 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 School ATSDBN/Name Borough Parent/Guardian's Signature Parent/Guardian's Name (Print) **Date Signed** SIGN HERE Parent/Guardian's Email Parent/Guardian's Address Home (\_\_\_\_\_\_ - \_\_\_\_ Cell Phone (\_\_\_\_\_)\_\_\_ - \_\_\_\_ **Alternate Emergency Contact's Name** Relationship to Student Contact Telephone Number ( ) -

#### For Office of School Health (OSH) Use Only **OSIS Number:** Received by: Name Date \_\_\_/\_\_/ Reviewed by: Name Date \_\_\_/\_\_/ ☐ Other Referred to School 504 Coordinator: ☐ Yes ☐ No □ 504 Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor (For supervised students only) ☐ School Based Health Center Date School Notified & Form Sent to DOE Liaison \_\_ / \_\_ / \_ \_ \_ Signature and Title (RN OR SMD): ☐ Modified Revisions as per OSH contact with prescribing health care practitioner ☐ Clarified