ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form—Office of School Health —School Year 2017–2018

ATTACH STUDENT PHOTO HERE	**Student** Last Name	First Name	Middle	Date of birth __/__/____ MM DD YYYY	Weight (kg) ____.__	☐ Male ☐ Female
				OSIS # __ __ __ __ __ __ __ __ __		
	School (include name, number, address and borough)			DOE District __ __	Grade	Class

The following section to be completed by Student's **HEALTH CARE PRACTITIONER**

Specify Allergy	Specify Allergy	Specify Allergy
☐ Allergy to	☐ Allergy to	☐ Allergy to

History of asthma?	☐ Yes (***If yes, student has an increased risk for a severe reaction***)					☐ No	**Does this student have the ability to:**		
History of anaphylaxis?	☐ Yes Date __/__/____					☐ No	Self-Manage	☐ Yes	☐ No
If yes, symptoms	☐ Respiratory	☐ Skin	☐ GI	☐ Cardiovascular	☐ Neurologic		Recognize signs of allergic reactions	☐ Yes	☐ No
Treatment	Date __/__/____						Recognize/avoid allergens independently	☐ Yes	☐ No
History of skin testing?	☐ Yes (attach copy of results) Date __/__/____					☐ No	Comments:		

Select In School Medications

1. ONLY SINGLE DOSE AUTO-INJECTORS SELECT BELOW

☐ **Epinephrine** Auto-Injector 0.15 mg
☐ **Epinephrine** Auto-Injector 0.3 mg
☐ Give antihistamine in addition to epinephrine **(must order antihistamine below)**

Select the most appropriate option for this student:

☐ Nurse-Dependent Student: nurse or trained school personnel must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer **

Practitioner's initials	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE

In School Instructions

PRN (check all that apply):

☐ Itching	☐ Shortness of Breath	☐ Vomiting / Diarrhea
☐ Hives	☐ Tightness / Closure	☐ Weak Pulse
☐ Swelling	☐ Hoarseness	☐ Pallor / Cyanosis
☐ Redness	☐ Wheezing	☐ Dizziness / Fainting

Specify signs, symptoms, or situations:

➢ Administer Intramuscularly into anterolateral aspect of thigh
➢ **Call 911 immediately**

If **no** improvement, repeat in ___ minutes for a maximum of __ times (not to exceed a total of **3** doses).

2. ORAL MEDICATION: ☐ **Diphenhydramine**

Preparation/Concentration: _____ Route _____

Select the most appropriate option for this student:

☐ Nurse-Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer **

Practitioner's initials	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE

PRN (check all that apply):

☐ Itchy / Runny Nose	☐ Itchy Mouth	☐ Few Hives
☐ Sneezing	☐ Mildly Itchy Skin	☐ Mild Nausea / Discomfort

Specify signs, symptoms, or situations:

Dose: _____ ☐ **4** hours **or** ☐ **6** hours as needed (specify)

If **no** improvement, indicate instructions:

3. ORAL MEDICATION: _____

Preparation/Concentration: _____ Route _____

Select the most appropriate option for this student:

☐ Nurse-Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer **

Practitioner's initials	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE

PRN *Specify signs, symptoms, or situations*:

Dose: _____ **Time interval:** ___ (specify min or hours)

Conditions under which medication should not be given:

If **no** improvement, indicate instructions:

HOME Medications (include over-the counter)	For Office of School Health (OSH) Use Only
	Revisions per OSH after consultation with prescribing practitioner. ☐ IEP

Health Care Practitioner (Please Print) LAST NAME	FIRST NAME	Signature	
Address		Tel. (___) ___-____	Fax. (___) ___-____
E-mail address		Cell (___) ___-____	
NYS License # **(Required)** _____		NPI # __ __ __ __ __ __ __ __ __ __	Date __/__/____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS
FORMS CANNOT BE COMPLETED BY A RESIDENT

TURN TO PAGE 2 ➔

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

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The Following Section to Be Completed by the Student's **Parent/Guardian**

I hereby consent to the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's health care practitioner. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. **I understand that all provided medication must be supplied in its original and UNOPENED medication box.** I further understand that I must immediately advise the school nurse) of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this consent is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction program session; or such time that I deliver to the school nurse a new prescription or instructions issued by my child's health care practitioner (whichever is earlier). By submitting this MAF, I am requesting that my child be provided specific health services by DOE and the New York City Department of Health and Mental Hygiene (DOHMH) through the Office of School Health (OSH). I understand that these services may include a clinical assessment and a physical examination by an OSH health care practitioner. Full and complete instructions regarding the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form.

I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request and consent for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I understand that OSH and DOE and their employees and agents may contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care practitioner and/or pharmacist that has provided medical or health services to my child.

SELF-ADMINISTRATION OF MEDICATION:

Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications:

INITIAL	I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further consent to my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, and for any and all consequences of my child's use of such medication in school. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.
INITIAL	I consent to the school nurse or trained school personnel storing and/or administering to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

*If you opt to use stocked, you must send your child's **epinephrine, asthma inhaler and other approved self-administered medications** with your child on a **school trip** day and/or after-school programs in order that he/she has it available. The stock epinephrine is **only** for use while your child is in the school building.*

SIGN HERE

Student Last Name First Name MI	Date of birth __/__/____	School
Print Parent/Guardian's Name	**Parent/Guardian's Signature**	
Parent/Guardian's Address	Date Signed __/__/____	
Telephone Numbers: Daytime (___)___-____	Home (___)___-____	Cell Phone (___)___-____
Parent/Guardian E-mail Address:		
Alternate Emergency Contact's Name:	Contact Telephone Number (___)___-____	

DO NOT WRITE BELOW – FOR OSH USE ONLY

Received by: Name Date __/__/____	**Reviewed by**: Name Date __/__/____
Self-Administers/Self-Carries: ☐ Yes ☐ No	**Services provided by**: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff
Signature and Title (RN OR MD/DO/NP):	

*Confidential information should not be sent by e-mail.