MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD BE USED FOR NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY

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	☐ Male ☐ Female
			OSIS Number ___ _____	
School (include name, number, address and borough)			**DOE District** ___ ___	**Grade** / **Class**

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

1. Diagnosis: _____ ICD-10 Code ☐ ___.___

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Select the most appropriate option for this student:

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**

_____ 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

☐ Standing daily dose: at __:__ AM / PM and __:__ AM / PM

AND/OR

☐ PRN _____
specify signs, symptoms, or situations

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

2. Diagnosis: _____ ICD-10 Code ☐ ___.___

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Select the most appropriate option for this student:

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**

_____ 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

☐ Standing daily dose: at __:__ AM / PM and __:__ AM / PM

AND/OR

☐ PRN _____
specify signs, symptoms, or situations

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

3. Diagnosis: _____ ICD-10 Code ☐ ___.___

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Select the most appropriate option for this student:

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**

_____ 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

☐ Standing daily dose: at __:__ am / pm and __:__ AM / PM

AND/OR

☐ PRN _____
specify signs, symptoms, or situations

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

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

Health Care Practitioner LAST NAME	FIRST NAME	(Please Print)	Signature
Address		Tel. No. (___)___-____	Fax. No (___)___-____
E-mail address		Cell phone (___)___-____	
NYS License No **(Required)** ___-_____		NPI No. _____	Date __/__/____

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The Following Section To Be Completed By 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 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 the Department or DOHMH 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 the Department, DOHMH 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 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.

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** (____)____-____	
Alternate Emergency Contact's Name	**Contact Telephone Number** (____)____-____

For OFFICE OF SCHOOL HEALTH (OSH) Only

Received by: Name Date ___/___/_____	Reviewed by: Name Date ___/___/_____
Referred to School 504 Coordinator: ☐ Yes ☐ No	Self-Administers/Self-Carries: ☐ Yes ☐ No
Services provided by: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center	
Signature and Title (RN OR MD/DO/NP):	Date School Notified & Form Sent to DOE Liaison ___/___/_____