

NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY
MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH
 Authorization for Administration of Medication to Students for School Year **2015-2016**

ATTACH STUDENT PHOTO HERE	Student Last Name	First Name	Middle	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	
					___/___/___ <small>M M D D Y Y Y Y</small>	
	School (include name, number, address and borough)				OSIS #	_____
				DOE District	Grade	Class
				_____	_____	_____

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

<p>1. Diagnosis: _____</p> <p>Medication: : _____</p> <p>Preparation/Concentration: _____</p> <p>Dose: _____ Route: _____</p> <p><u>Choose all options that are appropriate:</u></p> <p><input type="checkbox"/> Student may carry medication & may self-administer (PARENT MUST INITIAL REVERSE SIDE) CONTROLLED SUBSTANCES NOT ALLOWED.</p> <p><input type="checkbox"/> Store medication in medical room & student to self-administer with supervision (PARENT MUST INITIAL REVERSE SIDE).</p> <p><input type="checkbox"/> Store medication in medical room and nurse to administer.</p> <p>Student to carry & self-administer on school trips and/or after-school programs: <input type="checkbox"/> Yes (PARENT MUST INITIAL REVERSE SIDE) <input type="checkbox"/> No</p>	<p><u>In School Instructions</u></p> <p><input type="checkbox"/> Standing daily dose: at ___:___ AM / PM and ___:___ AM / PM AND/OR</p> <p><input type="checkbox"/> PRN</p> <p style="text-align: center;">_____</p> <p style="text-align: center;"><i>specify signs, symptoms, or situations</i></p> <p><input type="checkbox"/> Time interval: q ___ minutes or q ___ hours as needed.</p> <p><input type="checkbox"/> If no improvement, repeat in ___ minutes or ___ hours for a maximum of ___ times.</p> <p><u>Conditions under which medication should not be given:</u></p>
---	---

<p>2. Diagnosis: _____</p> <p>Medication: : _____</p> <p>Preparation/Concentration: _____</p> <p>Dose: _____ Route: _____</p> <p><u>Choose all options that are appropriate:</u></p> <p><input type="checkbox"/> Student may carry medication & may self-administer (PARENT MUST INITIAL REVERSE SIDE) CONTROLLED SUBSTANCES NOT ALLOWED.</p> <p><input type="checkbox"/> Store medication in medical room & student to self-administer with supervision (PARENT MUST INITIAL REVERSE SIDE).</p> <p><input type="checkbox"/> Store medication in medical room and nurse to administer.</p> <p>Student to carry & self-administer on school trips and/or after-school programs: <input type="checkbox"/> Yes (PARENT MUST INITIAL REVERSE SIDE) <input type="checkbox"/> No</p>	<p><u>In School Instructions</u></p> <p><input type="checkbox"/> Standing daily dose: at ___:___ AM / PM and ___:___ AM / PM AND/OR</p> <p><input type="checkbox"/> PRN</p> <p style="text-align: center;">_____</p> <p style="text-align: center;"><i>specify signs, symptoms, or situations</i></p> <p><input type="checkbox"/> Time interval: q ___ minutes or q ___ hours as needed.</p> <p><input type="checkbox"/> If no improvement, repeat in ___ minutes or ___ hours for a maximum of ___ times.</p> <p><u>Conditions under which medication should not be given:</u></p>
---	---

<p>3. Diagnosis: _____</p> <p>Medication: : _____</p> <p>Preparation/Concentration: _____</p> <p>Dose: _____ Route: _____</p> <p><u>Choose all options that are appropriate:</u></p> <p><input type="checkbox"/> Student may carry medication & may self-administer (PARENT MUST INITIAL REVERSE SIDE) CONTROLLED SUBSTANCES NOT ALLOWED.</p> <p><input type="checkbox"/> Store medication in medical room & student to self-administer with supervision (PARENT MUST INITIAL REVERSE SIDE).</p> <p><input type="checkbox"/> Store medication in medical room and nurse to administer.</p> <p>Student to carry & self-administer on school trips and/or after-school programs: <input type="checkbox"/> Yes (PARENT MUST INITIAL REVERSE SIDE) <input type="checkbox"/> No</p>	<p><u>In School Instructions</u></p> <p><input type="checkbox"/> Standing daily dose: at ___:___ AM / PM and ___:___ AM / PM AND/OR</p> <p><input type="checkbox"/> PRN</p> <p style="text-align: center;">_____</p> <p style="text-align: center;"><i>specify signs, symptoms, or situations</i></p> <p><input type="checkbox"/> Time interval: q ___ minutes or q ___ hours as needed.</p> <p><input type="checkbox"/> If no improvement, repeat in ___ minutes or ___ hours for a maximum of ___ times.</p> <p><u>Conditions under which medication should not be given:</u></p>
---	---

HOME Medications (include over-the-counter)	For DOHMH Only
	Revisions per DOHMH after consultation with prescribing provider.
	<input type="checkbox"/> IEP

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

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY
 MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH
 Authorization for Administration of Medication to Students for School Year 2015-2016

Student Last Name	First Name	MI	Date of birth ___/___/____	School
-------------------	------------	----	----------------------------	--------

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

I hereby authorize 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 physician. 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 if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the school nurse and the principal and/or his/her designee(s) 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 Authorization is only valid until the earlier of: (1) June 30, 2016 (This prescription may be extended through August if the student is attending a New York City Department of Education ("DOE") sponsored summer instruction program); or (2) such time that I deliver to the school nurse and the principal and/or his/her designee(s) a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed medication. By submitting this MAF, I am requesting that my child be provided with 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 part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of 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. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this MAF. I further understand that the OSH, DOE and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request, consent and authorization 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 hereby authorize OSH and DOE and their employees and agents, to 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 provider 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):**

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize 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, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize OSH and DOE, their agents and employees; including the school nurse, principal, his/her designee(s), and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. 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.

_____ I also authorize the school nurse, the principal, and/or his/her designee(s) to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ **I hereby certify that I have consulted with my child's health care provider and that I authorize the Office of School Health to administer stock Ventolin in the event that my child's asthma prescription medication is unavailable.**

*You must send your child's **Personal Metered Dose Inhaler (MDI)** with your child on a school trip day in order that he/she has it available.*

*The stock Ventolin is **only** for use while your child is in the school building.*

Parent/Guardian's Signature	Print Parent/Guardian's Name
Date Signed ___/___/____	Parent/Guardian's Address
Telephone Numbers: Daytime (____) _____ - _____ Home (____) _____ - _____ Cell Phone* (____) _____ - _____	
Parent/Guardian e-mail address*	
Alternate Emergency Contact's Name	Contact Telephone Number (____) _____ - _____
DO NOT WRITE BELOW - FOR DOE AND DOHMH ONLY	
Received by: Name _____ Date ___/___/____	Reviewed by: Name _____ Date ___/___/____
Self-Administers/Self-Carries: <input type="checkbox"/> Yes <input type="checkbox"/> No	Services provided by: <input type="checkbox"/> Nurse <input type="checkbox"/> DOHMH Public Health Advisor <input type="checkbox"/> School Based Health Center <input type="checkbox"/> DOE School Staff
Signature and Title (RN OR MD):	