

Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2018-2019
DUE: JULY 15th. Forms submitted after July 15th may delay processing for new school year

Student Last Name _____	First Name _____	Middle _____	Date of birth ____/____/____ MM DD YYYY	<input type="checkbox"/> Male	<input type="checkbox"/> Female
OSIS Number _____		Weight _____ kg			
School (include name, number, address and borough) _____			DOE District _____	Grade _____	Class _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	Specify Allergy	Specify Allergy
<input type="checkbox"/> Allergy to _____	<input type="checkbox"/> Allergy to _____	<input type="checkbox"/> Allergy to _____
History of asthma? <input type="checkbox"/> Yes (If yes, student has an increased risk for a severe reaction) <input type="checkbox"/> No	Does this student have the ability to:	
History of anaphylaxis? <input type="checkbox"/> Yes Date ____/____/____ <input type="checkbox"/> No	Self-Manage (See 'Student Skill Level' below) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, system affected <input type="checkbox"/> Respiratory <input type="checkbox"/> Skin <input type="checkbox"/> GI <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Neurologic	Recognize signs of allergic reactions <input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment _____ Date ____/____/____	Recognize/avoid allergens independently <input type="checkbox"/> Yes <input type="checkbox"/> No	
History of allergy testing? <input type="checkbox"/> Yes (attach copy of results) Date ____/____/____ <input type="checkbox"/> No	Comments: _____	

Select In School Medications

1. SEVERE REACTION

- **CALL 911**, Immediately administer:
- Epinephrine** Auto-Injector 0.15 mg
- Epinephrine** Auto-Injector 0.3 mg (retractable devices preferred) intramuscularly into the anterolateral of thigh for the following symptoms:
 - Shortness of breath, wheezing, or coughing
 - Fainting or dizziness
 - Lip or tongue swelling that bothers breathing
 - Pale or bluish skin color
 - Tight or hoarse throat
 - Vomiting or diarrhea (if severe or combined with other symptoms)
 - Weak pulse
 - Trouble breathing or swallowing
 - Feeling of doom, confusion, altered consciousness or agitation
 - Many hives or redness over body
- Other: _____
- If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____
 Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.
- If no improvement, or if symptoms recur, repeat in _____ minutes for maximum of _____ times (not to exceed a total of 3 doses)

Student Skill Level (select the most appropriate option)

- Dependent Student: nurse/nurse-trained staff 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/fieldtrips/school sponsored events.

2. MILD REACTION:

- Give antihistamine: Name: _____ Preparation/Concentration: _____ Dose: _____ Route: _____
 Frequency: Q4 hours or Q6 hours as needed for the following symptoms:
 - Itchy nose, sneezing, itchy mouth
 - A few hives
 - Mild stomach nausea or discomfort
 - Other: _____
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine.

Student Skill Level (select the most appropriate option)

- 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/fieldtrips/school sponsored events.

3. OTHER MEDICATION (e.g., inhaler/bronchodilator if child has asthma):

- Give Name: _____ Preparation/Concentration: _____ Dose: _____
 Route: _____ Frequency: Q _____ minutes hours as needed

Specify signs, symptoms, or situations: _____

If no improvement, indicate instructions: _____

Conditions under which medication should not be given: _____

Student Skill Level (select the most appropriate option)

- 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/fieldtrips/school sponsored events.

Home Medications (include over-the counter)

Health Care Practitioner Name LAST (Please Print)	FIRST	Signature _____	Date ____/____/____
Address _____		Tel. (____) _____	Fax. (____) _____
NYS License # (Required) _____	NPI # _____		

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PARENTS/GUARDIANS FILL BELOW

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 get another medicine for my child to use when he or she is not in school or is on a school trip.
 - 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 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), the Office of School Health (OSH) may provide health services to my child. These services may include 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).
 - 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.
 - 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.
 - If the school nurse is unavailable, I may be notified to come to school to give my child medicine.

SELF-ADMINISTRATION OF MEDICATION:

- 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 medicine if my child is temporarily unable to carry and give him or herself medicine.
- 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.

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
Print Parent/Guardian's Name			SIGN HERE →	
			Parent/Guardian's Signature	
Date Signed ___ / ___ / _____	Parent/Guardian's Email		Parent/Guardian's Address	
Telephone Numbers: Daytime (____) _____ - _____ Home (____) _____ - _____ Cell Phone (____) _____ - _____				
Alternate Emergency Contact's Name			Contact Telephone Number (____) _____ - _____	

For Office of School Health (OSH) Use Only

OSIS Number: _____			
Received by: Name	Date ___ / ___ / _____	Reviewed by: Name	Date ___ / ___ / _____
<input type="checkbox"/> 504 <input type="checkbox"/> IEP <input type="checkbox"/> Other		Referred to School 504 Coordinator: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Services provided by: <input type="checkbox"/> Nurse/NP <input type="checkbox"/> OSH Public Health Advisor (<i>For supervised students only</i>) <input type="checkbox"/> 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 health care practitioner			<input type="checkbox"/> Modified <input type="checkbox"/> Not Modified

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			SIGN HERE →	
Date Signed ___/___/_____	Parent/Guardian's Email		Parent/Guardian's Address	
Telephone Numbers: Daytime (____)____-____ Home (____)____-____ Cell Phone (____)____-____				
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For Office of School Health (OSH) Use Only

OSIS Number: _____

Received by: Name _____ Date ___/___/_____ Reviewed by: Name _____ Date ___/___/_____

504 IEP Other Referred to School 504 Coordinator: Yes No

Services provided by: Nurse/NP OSH Public Health Advisor (For supervised students only) 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 health care practitioner Modified Not Modified

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HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	Specify Allergy	Specify Allergy
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History of asthma? <input type="checkbox"/> Yes (If yes, student has an increased risk for a severe reaction) <input type="checkbox"/> No	Does this student have the ability to:	
History of anaphylaxis? <input type="checkbox"/> Yes Date ____/____/____ <input type="checkbox"/> No	Self-Manage (See 'Student Skill Level' below) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, system affected <input type="checkbox"/> Respiratory <input type="checkbox"/> Skin <input type="checkbox"/> GI <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Neurologic	Recognize signs of allergic reactions <input type="checkbox"/> Yes <input type="checkbox"/> No	
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Home Medications (include over-the counter)

Health Care Practitioner Name LAST	FIRST	Signature	Date ____/____/____
Address		Tel. (____) _____ - _____	Fax. (____) _____ - _____
NYS License # (Required)	NPI #		