ASTHMA MEDICATION ADMINISTRATION FORM

Student Last Name Fi	rst Name Mide	dle Initial	Date of Birth/	<u></u>	Male Female
OSIS #	DO	E District		Grade/Class	
School Name, Number, Address	, and Borough:				
HE	ALTH CARE PRACT	TITIONER	S COMPLETE BEL	ow	
Diagnosis Asthma Other:	Control (see M Well Co Not Con Unknow	ontrolled htrolled / Po	nes) porly Controlled	Severity (see NAEPP Guid Intermittent Mild Persistent Moderate Persisten Severe Persistent	
Student Asthn	na Risk Assessment (Questionn	aire (Y = Yes, N = N	lo, U = Unknown)	
History of near-death asthma requiring mechanical ventilation Y N U History of life-threatening asthma (loss of consciousness or hypoxic seizure) Y N U History of asthma-related PICU admissions (ever) Y N U Received oral steroids within past 12 months Y N U History of asthma-related ER visits within past 12 months Y N U					
Student Skill Level (Select the most appropriate option) Home Medications (Include over the counter) Nurse-Dependent Student: nurse must administer medication Reliever Supervised Student: student self-administers under adult supervision Reliever Independent Student: student is self-carry / self-administer Controller I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events. Other					
Quick Relief In-School Medication	on (Select <u>QNE)</u>		In-School Instru	ctions (Check all that ap	oly)
 Albuterol MDI [Ventolin[®] MDI can be provided by school for shared usage (plus individual spacer)]: MDI w/ spacer DPI Other: Name: Strength: Dose: Route: Time Interval: □ hrs Standard Order: Give 2 puffs/1 AMP q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath ("asthur flare symptoms"). Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE. If in Respiratory Distress*: Call 911 and give 6 puffs/1 AMP; n					for coughing, breath ("asthma ee. If not buffs/1 AMP; may until EMS arrives. prcise.
Controller Medications for In-School Administration (Recommended for Persistent Asthma, per NAEPP Guidelines) <pre> Standing Daily Dose: puffs/1AMP ONCE a day atAM Special Instructions: </pre> MDI w/ spacer DPI Other: Name: Strength: Dose: Route: Time Interval: D hrs					
Health Care Practitioner (Please I	•	Signat	ure		,
Last First Address Tel.	()	Fax ()	Date /	= <u>'</u>
Email Address	NYS Licen	se # (Requ	ired)	CDC and AAP strongly annual influenza vacci children diagnosed wit	nation for all

FORMS CANNOT BE COMPLETED BY A RESIDENT

ASTHMA MEDICATION ADMINISTRATION FORM

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following: I consent to my child's medicine being stored and given at school based on directions from my child's health care practitione consent to any equipment needed for my child's medicine and equipment, including non-Ventolin inhales. Inderstand that: I understand that: All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original b 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) m name. 2) pharmacy name and phone number, 3) my child's doctor's name. 4) date, 5) number of refills, 6) medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions. Isust immediately tell the school nurse about my child's medicine or the doctor's instructions. OSH and its agents involved in providing the above heath services (or 0.5) heath care practitioner or nurse. The medication administration form (MAF), the Office of School Heath (OSH) may provide heath services to r These services may include a clinical assessment or a physical exam by an OSH heath 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, o give the school nurse a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse mactitioner multicare maximum my child's health care practitioner multicare may also and early solary school nurse stating not wart my child be the school nurse and wAF is earlier). When this medication order expires, I will give my child's school nurse a new MAF for my school nurse settime orders will	
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ernate Emergency Contact Name: Emergency Contact Phone: ()	
For OFFICE OF SCHOOL HEALTH (OSH) Use Only	
IS Number: 504 [] IEP [] Othe	
ceived By Name: Date// Reviewed By Name: Date/	_/
Invices Nurse/NP OSH Public Health Advisor (For supervised students only) Dovided By School-Based Health Center OSH Asthma Case Manager (For supervised students only)	

Services					
Revisions per Office of School Health after consultat	ion with prescribing practitioner:				
Signature and Title (RN OR MD/DO/NP):	*Respiratory Distress: includes breathlessness at rest, tachypnea, cyanosis, pallor, hunching forward, nasal flaring, accessory respiratory muscle use, abdominal breathing, shallow rapid breathing, mouthing words, wheezing throughout expiration and inspiration or decreased or absent breath sounds, agitation, drowsiness, confusion or exceptionally quiet appearance.				

Confidential information should not be sent by email

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year 2018-2019

DUE: JULY 15th. Forms submitted after July 15th may delay processing for new school year.

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, including non-Ventolin inhalers.
 - 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 doctor'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 doctor'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).
 - When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse stating that I do not want my child to be examined by an OSH health care practitioner. The OSH health care practitioner may assess my child's asthma symptoms and response to prescribed asthma medicine. The OSH health care practitioner may decide if the medication orders will remain the same or need to be changed. The OSH health care practitioner will fill out a new MAF so my child can continue to receive health services through OSH. OSH will not need my signature to write future asthma MAFs. If the OSH health care practitioner completes a new MAF for my child, the OSH health care practitioner will attempt to inform me and my child's health care practitioner.
 - This form represents my consent and request for the asthma 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.

FOR SELF ADMINISTRATION OF MEDICINE:

- 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 medicine is not available.

NOTE: If you opt to use stock medication, you must send your child's asthma inhaler, epinephrine, and other approved self-administered medications with your child on a school trip day and/or after-school program in order for he/she to have it available. Stock medications are for use by OSH staff in school only.

Student Last Name	First		МІ	Date of Birth//
Parent/Guardian Print Name:		SIGN HEF	RE Signatu	re:
Date Signed / /	Parent/Guardian's Add	ress:		
Cell Phone ()	Other Phone ()		Emai	l:
Alternate Emergency Contact Name:		Emerge	ency Contact	Phone: ()/

For OFFICE OF SCHOOL HEALTH (OSH) Use Only

OSIS Number:				504 IEP Other			
Received By Name:	Date	_//	Reviewed By Name:	Date//			
Services Nurse/NP OSH Public Health Advisor (For supervised students only) Provided By School-Based Health Center OSH Asthma Case Manager (For supervised students only)				udents only) students only)			
Revisions per Office of Sch	ool Health after consultation	with prescribing	practitioner: Modified No	t Modified			
Signature and Title (RN OF	MD/DO/NP):	flaring, accessor throughout expire	*Respiratory Distress: includes breathlessness at rest, tachypnea, cyanosis, pallor, hunching forward, nasal flaring, accessory respiratory muscle use, abdominal breathing, shallow rapid breathing, mouthing words, wheezing throughout expiration and inspiration or decreased or absent breath sounds, agitation, drowsiness, confusion or exceptionally quiet appearance.				

Confidential information should not be sent by email

photo PROVIDER MI	EDICATION OF	DER FORM	Office	INISTRATIC of School Healt y delay processing	DN FORM h School Year 2018-2019 for new school year.
Student Last Name	First Name	Middle Ir		Date of Birth/ M_M	$ \begin{vmatrix} - & - \\ -$
OSIS #		DOE Dis	strict		Grade/Class
School Name, Number, A	ddress, and Borou	igh:			
<u></u>	HEALTH CA		NERS	COMPLETE BEL	.ow
Diagnosis Asthma Other:	C	ontrol (see NAEPP	led	·	Severity (see NAEPP Guidelines) Intermittent Mild Persistent Moderate Persistent Severe Persistent
Studen	t Asthma Risk As	sessment Ques	stionnai	re (Y = Yes, N = N	No, U = Unknown)
History of near-death asthm History of life-threatening as History of asthma-related P Received oral steroids with History of asthma-related E History of asthma-related h History of food allergy or ec	sthma (loss of conscion ICU admissions (ev in past 12 months R visits within past ospitalizations with	usness or hypoxic sei rer) 12 months in past 12 month	izure))Y ON OU)Y ON OU)Y ON OU)Y ON OU)Y ON OU)Y ON OU)Y ON OU	times last : / / / times times
	tudent: nurse must ac student self-adminis	dminister medicatio ters under adult su y / self-administer e ability to self-admini	pervision	scribed	Medications (Include over the counter) ever troller er
Quick Relief In-School M Albuterol MDI [Ventolin® MDI can be pro (plus individual spacer)]: MDI w/ spacer DPI Other: Name: Dose: Route: _	ovided by school for s	shared usage	wheezing, flare symp symptom- If in F Pre-e URI S 2 puff	ard Order: Give 2 p tight chest, difficulty t toms"). Monitor for 20 free within 20 mins ma tespiratory Distres kercise: 2 puffs/1 AM	 ss*: Call 911 and give 6 puffs/1 AMP; may repeat q 20 minutes until EMS arrives MP 15-20 mins before exercise. nt Asthma Flare (Within 5 days):
Controller Medications f (Recommended for Persistent As Fluticasone MDI [Flovent® 110 mcg MDI o MDI w/ spacer DPI Other: Name: Dose: Route: Health Care Practitioner (I Last Address	thma, per NAEPP Guide can be provided by so Stren Time Inten Please Print Name) First	olines) chool for shared us ngth: val: □ hrs)	Signatu	Special Instruc	P ONCE a day at AM ctions: Date / /
Email Address	Tel. () _	⁻) ed)	NPI #

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. REV 3/18 FORMS CANNOT BE COMPLETED BY A RESIDENT