Department of Education

GUIDELINES FOR HEALTH SERVICES AND SECTION 504 ACCOMMODATIONS FOR STUDENTS IN NEW YORK CITY PUBLIC SCHOOLS

SCHOOL YEAR 2020-2021

To All Parents and Health Care Practitioners:

The NYC Department of Education (DOE) and the Office of School Health (OSH) work together to provide services to all students with special needs. These services allow students to fully participate in school. If your child needs health services and accommodations under Section 504 of the Rehabilitation Act, complete the form(s) in this packet. The NYC Department of Education **requires** a new approval for services each school year

There are three types of health services and accommodations forms:

1. **Medication Administration Forms (MAFs)** – This form is completed by your child's medical provider to receive medicine or treatment at school.
    - There are five separate MAFs: asthma; allergies; diabetes; seizures and general.
    - Please submit completed forms to the school nurse.
2. **Medically Prescribed Treatment (Non-Medication) Form** – This form is completed by your child's medical provider to request special procedures such as tube feeding catheterization, suctioning, etc. to be performed at school. This form may be used for all skilled nursing treatments.
    - Please submit completed forms to the school nurse.
3. **Request for Section 504 Accommodation(s)** – Complete this form to request special services such as a barrier-free building, elevator use, testing modification, etc.
    - Do **NOT** use this form for related services such as occupational therapy, physical therapy, speech and language therapy, counseling, etc. Related services should be provided through an Individualized Education Program (IEP).
    - There are two separate forms that must be completed: one for parents, and one for your child's medical provider
    - Please submit completed forms to your school's 504 Coordinator

Parents:

- Please take your child to his or her health care practitioner every year to complete these forms.
- **These forms should be submitted to your school nurse by June 1, 2020 for the new school year. Forms received after this date may delay processing.**
- If the school nurse is unavailable, you may be notified to come to school to give your child medicine.
- If you decide to use the school's stock medicine, you must send your child's epinephrine, asthma inhaler, and other approved self-administered medicines with your child on a school trip day and/or after school programs in order that he/she has it available. Stock medications are for use by OSH staff in school only.
- **Please make sure you sign the back of the form so that your child can receive these services in school**
- **Attach a small current photo to the upper left corner of the medication form(s). This helps the school to properly identify your child**.

Please reach out to the student's school nurse and/or the school's 504 Coordinator if you have any questions. Thank you for your assistance.

Health Care Practitioners: please see back of page.

Department of Education

GUIDELINES FOR HEALTH SERVICES AND SECTION 504 ACCOMMODATIONS FOR STUDENTS IN NEW YORK CITY PUBLIC SCHOOLS

SCHOOL YEAR 2020-2021

Health Care Practitioner Instructions for Completion of the Request for Accommodations Form

Please follow these guidelines when completing the forms:

- Your patient may be treated by several health care practitioners. The health care practitioner completing the form should be the one treating the condition for which services are requested.
- This form must be completed by the student's licensed medical provider (MD, DO, NP, PA) who has treated the student and can provide clinical information concerning the medical diagnoses outlined as the basis for this request. Forms cannot be completed by the parent/guardian. Forms cannot be completed by a resident.

All requests for accommodations are based on medical necessity. Please ensure that your answers are complete and accurate. **All requests for medical accommodations will be reviewed by the Office of School Health (OSH) clinical staff, who will contact you if additional clarification is needed.** There is a school nurse present in most schools. Requests for 1:1 nursing will be reviewed on a case-by-case basis.

- Please clearly type or print all information on this form. **Illegible, incomplete, unsigned or undated forms cannot be processed and will be returned to the student's parent or guardian.**
- Provide the full name and current diagnoses of clinical relevance for the student.
- Describe the impact of the diagnoses/symptoms, medical issues, and/or behavioral issues that may affect the student during school hours or transport, including limitations and/or interventions required.
- Include any documentation and test results for any specialty services or referrals relevant to the accommodations requested.
- Only request services that are needed during school hours. Do not request medicine that can be given at home, before or after school hours.
- If a student requires medications or procedures to be performed, please complete and submit all relevant Medication Administration Forms (MAFs) and/or a Request for Medically Prescribed Treatment. The orders should be specific and clearly written. This allows the school nurse to carry it out in a clinically responsible way.
- Requests for alternative medicines will be reviewed on a case-by-case basis.
- Clearly print your name and include the valid New York State, New Jersey, or Connecticut license and NPI number.
- On the Medical Accommodations Request Form:
    - Please list the days and times that are best to contact you to provide further clarification of the request.
    - Please sign the attestation documenting that the information provided is accurate.
- Epinephrine may be stored in the classroom, in a common area, or transported with students as indicated in their Allergy Response Plan.

Student Skill Level: Students should be as self-sufficient as possible in school. Health Care Practitioners must determine whether the child is nurse-dependent, should be supervised, or is independent to take medicine or perform procedures

- **Nurse-Dependent Student:** nurse must administer. Medicine is typically stored in a locked cabinet in the medical room.
- **Supervised Student:** student self-administers, under adult supervision. The student should be able to identify their medicine, know the correct dose and when to take it, understand the purpose of their medicine, and be able to describe what will happen if it is not taken.
- **Independent Student:** student can self-carry/self-administer. For students who are independent, initial the section of the form that allows student to self-administer at school and during trips. **Students are never allowed to carry controlled substances.**
- ***If no skill level is selected, OSH clinical staff will designate the student as nurse-dependent by default, until further advised by the student's health care practitioner.***

Thank you for your cooperation.

Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year

Student Last Name	First Name	Middle	**Date of birth** __ __/__ __/__ __ __ __ M M D D Y Y Y Y	○ Male ○ Female
OSIS Number __ __ __ __ __ __ __ __ __	**Weight** _____ kg			
School (include ATSDBN/name, number, address and borough)			**DOE District** __ __	**Grade** / **Class**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

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 *(See 'Student Skill Level' below)*	☐ Yes	☐ No
If yes, system affected	☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic		Recognize signs of allergic reactions	☐ Yes	☐ No
Treatment	Date __ __/__ __/__ __ __ __		Recognize/avoid allergens independently	☐ Yes	☐ No

Select In School Medications

1. SEVERE REACTION

A. **Immediately administer epinephrine ordered below, then call 911.**

☐ 0.15 mg
☐ 0.3 mg

Give intramuscularly in the anterolateral thigh for **any** of the following symptoms *(retractable devices preferred)* :

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms
- Feeling of doom, confusion, altered consciousness or agitation

☐ 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**.

B. If no improvement, or if symptoms recur, repeat in _____ minutes for maximum of _____ times (not to exceed a total of 3 doses)

C. Give antihistamine after epinephrine administration (*order antihistamine below*)

Student Skill Level *(select the most appropriate option)*
☐ Nurse-Dependent Student: nurse/nurse-trained staff must administer
☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

2. MILD REACTION

A. Give antihistamine: Name:_____Preparation/Concentration:_____ Dose:_____ Route: _____
Frequency: ☐ **Q4** hours **or** ☐ **Q6** hours as needed for **any** of the following symptoms:

- Itchy nose, sneezing, itchy mouth
- A few hives or mildly itchy skin
- Mild stomach nausea or discomfort
- Other: _____

B. If symptoms of severe allergy/anaphylaxis develop, or if more than one symptom from each system is present, use epinephrine and call 911.

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

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

3. OTHER MEDICATION

- 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

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

Home Medications *(include over-the counter)*

Health Care Practitioner Name LAST FIRST (**Please print and circle one:** MD, DO, NP, PA)		Signature	Date __ __/__ __/__ __ __ __
Address		Tel. (___)___-____	Fax. (___)___-____
NYS License # **(Required)**	NPI # __ __ __ __ __ __ __ __ __ __		

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 4/20 **PARENTS MUST SIGN PAGE 2 ➔**

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2020–2021

Please return to school nurse. Forms submitted after June 1st 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. 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 provide the school with current, unexpired medicine for my child's use during school days.**
     - 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 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.
   - 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), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to 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. OSH will not need my signature for future MAFs.
   - 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.
   - For the purposes of providing care or treatment for my child, 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.

SELF-ADMINISTRATION OF MEDICATION (INDEPENDENT STUDENTS ONLY):

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

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 ATSDBN/Name	Borough	District
Parent/Guardian's Name (Print) 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	**Relationship to Student**	**Contact Telephone Number** (__ __ __) __ __ __ - __ __ __ __

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

*Confidential Information should not be sent by email

FOR PRINT USE ONLY

Attach student photo here

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year **2020-2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name First Name Middle Initial | Date of Birth __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y) | ☐ Male ☐ Female

OSIS # __ __ __ __ __ __ __ __ __ | DOE District __ __ | Grade/Class _____

School ATSDBN/Name Address, and Borough:

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
- ☐ Asthma
- ☐ Other:_____

Control (*see NAEPP Guidelines*)
- ☐ Well Controlled
- ☐ Not Controlled / Poorly Controlled
- ☐ Unknown

Severity (*see NAEPP Guidelines*)
- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, 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 ☐	☐	____ times last : __ __ /__ __ /__ __
History of asthma-related ER visits within past 12 months	Y ☐	N ☐	U ☐	☐	____ times
History of asthma-related hospitalizations within past 12 months	Y ☐	N ☐	U ☐	☐	____ times
History of food allergy or eczema, specify: _____	Y ☐	N ☐	U ☐	☐	

Student Skill Level *(Select the most appropriate option)*
- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers under adult supervision
- ☐ Independent Student: student is self-carry/self-administer
  I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

_____ Practitioner Initials

Quick Relief In-School Medication

☐ **Albuterol** [*Only generic Albuterol MDI is provided by school for shared usage] (plus individual spacer)*: ☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standard Order: Give 2 puffs q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath.
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; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** 2 puffs @ noon for 5 school days.
Special Instructions:

☐ **Other**: Name: _____ Strength: _____
Dose: _____ Route: _____ Frequency: ___ hrs

Give ___ puffs/____AMP q ___ hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. 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 __ puffs/ ___AMP; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** __ puffs/___ AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** ___ puffs/___ AMP @ noon for 5 school days
Special Instructions:

Controller Medications for In-School Administration

(*Recommended for Persistent Asthma, per NAEPP Guidelines*)

☐ **Fluticasone** [Only *Flovent® 110 mcg MDI is provided by school for shared usage*]
☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standing Daily Dose:___ puffs ONCE a day at ___ AM
Special Instructions:

☐ **Other ICS Standing Daily Dose:**
Name: _____ Strength: _____
Dose: _____ Route: _____ Frequency: ___ hrs

Home Medications *(Include over the counter)*

☐ Reliever _____ ☐ Controller _____ ☐ Other _____

Health Care Practitioner (**Please print name and circle one**: MD, DO, NP, PA) Last First		Signature	Date __ __ /__ __ /__ __ __ __
Address	Tel. (_ _ _) _ _ _ - _ _ _ _	Fax (_ _ _) _ _ _ - _ _ _ _	NPI # _ _ _ _ _ _ _ _ _ _
Email Address	NYS License # **(Required)**	CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.	

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. | **REV 4/20**

FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 ➔

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year **2020-2021**

Please return to school nurse. Forms submitted after June 1, 2020 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-albuterol 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 provide the school with current, unexpired medicine for my child's use during school days.**
     - 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 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.
   - 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), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to 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 may fill out a new MAF so my child can continue to receive health services through OSH. My health care practitioner or the OSH health care practitioner 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.
   - For the purposes of providing care or treatment to my child, 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.

FOR SELF ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- 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.

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 _____ MI _____ | Date of Birth __ __/__ __/__ __ __ __

School ATSDBN/Name _____ | **District** _____ | **Borough** _____

Parent/Guardian Print Name: _____ **SIGN HERE** **Signature:** _____

Date Signed __ __ / __ __ / __ __ __ __ Parent/Guardian's Address: _____

Cell Phone (_ _ _) _ _ _ - _ _ _ _ Other Phone (_ _ _) _ _ _ - _ _ _ _ **Email:** _____

Other Emergency Contact Name/Relationship: _____ Emergency Contact Phone: (_ _ _) _ _ _ - _ _ _ _

For OFFICE OF SCHOOL HEALTH (OSH) Use Only

OSIS Number: __ __ __ __ __ __ __ __ __ ☐ 504 ☐ IEP ☐ Other

Received By Name: _____ Date __ __/__ __/__ __ | Reviewed By Name: _____ Date __ __/__ __/__ __

Services Provided By ☐ Nurse/NP ☐ School-Based Health Center ☐ OSH Public Health Advisor *(For supervised students only)* ☐ OSH Asthma Case Manager *(For supervised students only)*

Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Modified ☐ Not Modified

Signature and Title (RN OR MD/DO/NP): _____

Confidential information should not be sent by email

FOR PRINT USE ONLY

Attach student photo here

DIABETES MEDICATION ADMINISTRATION FORM [PART A]

Provider Medication Order Form – Office of School Health – School Year **2020-2021**

DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945

Student Last Name	First Name	MI	**Date of Birth**	☐ Male ☐ Female	**OSIS #**
School (include ATSDBN/name, address and borough)			**DOE District**	**Grade**	**Class**

HEALTH CARE PRACTITIONER COMPLETES BELOW *[Please see 'Provider Guidelines for DMAF Completion']*

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Non-Type 1/Type 2 Diabetes ☐ Other Diagnosis: _____

Recent A1C: Date __ __ / __ __ / __ __ __ __ Result _____.___%

Orders written will be for Sept. '20 through Aug '21 school year unless checked here: ☐ Current School Year '19-'20 and '20-'21

EMERGENCY ORDERS

Severe Hypoglycemia

Administer **Glucagon** and **call 911**

Glucagon: ☐ 1 mg ☐ ___ mg SC/IM

GVOKE: ☐ 1 mg ☐ ___ mg SC/IM

Baqsimi: ☐ 3 mg Intranasal

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration.

Risk for Ketones or Diabetic Ketoacidosis (DKA)

☐ Test **ketones** if bG > ____ mg/dl, or if vomiting, or fever > 100.5F

OR

☐ Test ketones if bG > __ mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5F

- If small or trace give water; re-test ketones & bG in 2 hrs or ___ hrs
- If ketones are moderate or large, give water:
  Call parent and Endocrinologist; ☐ **NO GYM**
  If ketones and vomiting, unable to take PO and MD not available, **CALL 911**

☐ Give insulin correction dose if > 2 hrs or __ hours since last insulin.

SKILL LEVEL

Blood Glucose (bG) Monitoring Skill Level

☐ Nurse / adult must check bG.

☐ Student to check bG with adult supervision.

☐ Student may check bG without supervision.

Insulin Administration Skill Level

☐ Nurse-Dependent Student: nurse must administer medication

☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: self-carry / self-administer *(MUST Initial attestation)*
I attest that the **independent** student demonstrated the ability to self-administer the prescribed medication effectively for school, field trips, & school/sponsored events

PROVIDER INITIALS

NOTE: Trip nurse not required for supervised or independent students.

BLOOD GLUCOSE MONITORING *[See Part B for CGM readings]*

Specify times to test in school (must match times for treatment and/or insulin) ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

Hypoglycemia: *Check all boxes needed. Must include at least one treatment plan.*

☐ T2DM - no bG monitoring or insulin in school

☐ For bG < _____ mg/dl give _____ gm rapid carbs at: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN
Repeat bG testing in 15 or ____ min. If bG still < _____ mg/dl repeat carbs and retesting until bG > _____ mg/dl.

15 gm rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz.

☐ For bG < _____ mg/dl give _____ gm rapid carbs at: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN
Repeat bG testing in 15 or ____ min. If bG still < _____ mg/dl repeat carbs and retesting until bG > _____ mg/dl.

☐ For bG < _____ mg/dl pre-gym, **no gym** ☐ For bG < _____ mg/dl ☐ Pre-gym; ☐ PRN; treat hypoglycemia then give snack.

Snack orders on DMAF Part B

Insulin is given before food unless noted here: ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

Mid-range Glycemia: *Insulin is given before food unless noted here:* ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give snack before gym

Hyperglycemia: *Insulin is given before food unless noted here:* ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

☐ No Gym For bG > ___ mg/dl ☐ Pre-gym and/or ☐ PRN

☐ For bG > ___ mg/dl PRN, Give insulin correction dose if > 2 hrs or __ hrs since last insulin ☐ For bG meter reading "**High**" use bG of 500 or___ mg/dl.

☐ **Check bG or Sensor Glucose (sG) before dismissal**

☐ Give correction dose pre-meal and carb coverage after meal

☐ For sG or bG values < ___ mg/dl treat for hypoglycemia if needed, and give ___ gm carb snack before dismissed

☐ For sG or bG values <___ mg/dl treat for hypoglycemia if needed, and do not send on bus/mass transit, parent to pick up from school.

INSULIN ORDERS

Name of Insulin*:

_____

* May substitute Novolog with Humalog/Admelog

☐ No Insulin in School

☐ No Insulin at Snack

Delivery Method:

☐ Syringe/Pen

☐ Pump *(Brand)*:

_____

☐ Smart Pen – use pen suggestions

Insulin Calculation Method:

☐ Carb coverage **ONLY** at: ☐ Breakfast ☐ Lunch ☐ Snack

☐ Correction dose **ONLY** at: ☐ Breakfast ☐ Lunch ☐ Snack

☐ Carb coverage **plus** correction dose when bG > Target **AND** at least 2 hrs or ___ hrs. since last insulin at ☐ Breakfast ☐ Lunch ☐ Snack
Correction dose calculated using: ☐ ISF **or** ☐ Sliding Scale

☐ Fixed Dose *(see Other Orders)*

☐ Sliding Scale *(See Part B)*

☐ If gym/recess is immediately following lunch, subtract ___ gm carbs from lunch carb calculation.

Insulin Calculation Directions: *(give number, not range)*

Target bG = _____ mg/dl

Insulin Sensitivity Factor (ISF):
1 unit decreases bG by ___ mg/dl
(time: _____ to _____)
1 unit decreases bG by ___ mg/dl:
(time: _____ to _____)

If only one ISF, time will be 8am to 4pm if not specified.

Insulin to Carb Ratio (I:C):

Bkfast **OR** time: ____ to ____
1 unit per ___ gms carbs

Snack **OR** time: ____ to ____
1 unit per ___ gms carbs

Lunch **OR** time: ____ to ____
1 unit per ___ gms carbs

Lunch followed by gym
1 unit per ___ gms carbs

Carb Coverage:	**Correction Dose using ISF:**	Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have ½ unit marks; unless otherwise instructed by PCP/Endocrinologist. Round DOWN to nearest 0.1 unit for pumps, unless following pump recommendations or PCP/Endocrinologist orders.
# gm carb in meal = X units insulin # gm carb in I:C	bG – Target bG = X units insulin ISF	

For Pumps - Basal Rate in school:

__:___ AM/PM to __:__ AM/PM _____ units/hr

__:___ AM/PM to __:__ AM/PM _____ units/hr

__:___ AM/PM to __:__ AM/PM _____ units/hr

☐ Student on FDA approved hybrid closed loop pump-basal rate variable per pump.

☐ Suspend/disconnect pump for gym

☐ Suspend pump for hypoglycemia not responding to treatment for ____ min.

Additional Pump Instructions:

☐ Follow pump recommendations for bolus dose *(if not using pump recommendations, will round down to nearest 0.1 unit)*

☐ For bG > ___ mg/dl that has not decreased in __ hours after correction, consider pump failure and notify parents.

☐ For suspected pump failure: SUSPEND pump, give insulin by syringe or pen, and notify parents.

☐ For pump failure, only give correction dose if > __ hrs since last insulin

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 4/20

HEALTH CARE PRACTITIONERS: COMPLETE 'PART B' AND SIGN ➔

Student Name (Last, First): _____, _____ OSIS Number: _____

DIABETES MEDICATION ADMINISTRATION FORM [PART B]

Provider Medication Order Form – Office of School Health – School Year **2020-2021**

DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945

CONTINUOUS GLUCOSE MONITORING (CGM) ORDERS *[Please see 'Provider Guidelines for DMAF Completion']*

☐ Use CGM readings - For CGM's used to replace finger stick bG readings, only devices FDA approved for use and age may be used within the limits of the manufacturer's protocol. (sG = sensor glucose).

Name and Model of CGM: _____

For CGM used for insulin dosing: finger stick bG will be done when: the symptoms don't match the CGM readings; if there is some reason to doubt the sensor (i.e. for readings <70 mg/dl or sensor does not show both arrows and numbers)

☐ CGM to be used for insulin dosing and monitoring - **must be FDA approved for use and age**

sG Monitoring Specify times to check sensor reading: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN [*if none checked, will use bG monitoring times]*
For sG <70mg/dl check bG and follow orders on DMAF, unless otherwise ordered below.
Use CGM grid below OR ☐ See attached CGM instruction

CGM reading	Arrows	Action ☐ use < 80 mg/dl instead of < 70 mg/dl for grid action plan
sG < 60 mg/dl	Any arrows	Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.
sG 60-70 mg/dl	and ↓, ↓↓, ↘ or →	Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.
sG 60-70 mg/dl	and ↑ , ↑↑, or ↗	If symptomatic, treat hypoglycemia per bG hypoglycemia plan; if not symptomatic, recheck in 15-20 minutes. If still <70 mg/dl check bG.
sG >70 mg/dl	Any arrows	Follow bG DMAF orders for insulin dosing
sG ≤ 120 mg/dl pre-gym or recess	and ↓, ↓↓	Give 15 gms uncovered carbs. If gym or recess is immediately after lunch, subtract 15 gms of carbs from lunch carb calculation.
sG ≥ 250	Any arrows	Follow bG DMAF orders for treatment and insulin dosing

☐ For student using CGM, wait 2 hours after meal before testing ketones with hyperglycemia.

PARENTAL INPUT INTO INSULIN DOSING

☐ Parent(s)/Guardian(s) (*give name*), _____, may provide the nurse with information relevant to insulin dosing, including dosing recommendations. Taking the parent's input into account, the nurse will determine the insulin dose within the range ordered by the health care practitioner and in keeping with nursing judgment.

Please select **one** option below:

1. ☐ Nurse may adjust calculated dose up or down up to __ units based on parental input and nursing judgment.

2. ☐ Nurse may adjust calculated dose up by ___% or down by ___% of the prescribed dose based on parental input and nursing judgment

MUST COMPLETE: **Health care practitioner can be reached for urgent dosing orders at: (__ __ __) __ __ __ - __ __ __ __**
If the parent requests a similar adjustment for > 2 days in a row, the nurse will contact the health care practitioner to see if the school orders need to be revised.

SLIDING SCALE

Do NOT overlap ranges (e.g. enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. Use pre-treatment bG to calculate insulin dose unless other orders.

	bG	Units Insulin		bG	Units Insulin
☐Lunch	Zero - ____	_____	☐Other	Zero - ____	_____
☐Snack	____ - ____	_____	Time	____ - ____	_____
☐Breakfast	____ - ____	_____	_____	____ - ____	_____
☐Correction	____ - ____	_____	☐Snack	____ - ____	_____
Dose	____ - ____	_____	☐Breakfast	____ - ____	_____
	____ - ____	_____	☐Correction	____ - ____	_____
	____ - ____	_____	Dose	____ - ____	_____

OPTIONAL ORDERS

☐ Round insulin dosing to nearest whole unit: 0.51-1.50u rounds to 1.00u.
☐ Round insulin dosing to nearest half unit: 0.26-0.75u rounds to 0.50 u (must have half unit syringe/pen).
☐ Use sliding scale for correction AND at meals ADD: __units for lunch; __ units for snack; __ units for breakfast (sliding scale must be marked as correction dose only).
☐ Long acting insulin given in school – Insulin Name: _____
Dose: ____ units Time _____ or ☐ Lunch

SNACK ORDERS

☐ Student may carry and self-administer snack
Snack time of day: ___ AM / PM ☐ Pre-gym Snack
Type & amount of snack: _____

OTHER ORDERS:

HOME MEDICATIONS

Medication	Dose	Frequency	Time	Route
Insulin:				
Other:				

ADDITIONAL INFORMATION

Is the child using altered or non-FDA approved equipment? ☐ Yes or ☐ No [*Please note that New York State Education laws prohibit nurses from managing non-FDA devices. Please provide pump-failure and/or back up orders on DMAF Part A Form.]*

By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s).

Health Care Practitioner Name LAST FIRST		Signature	
(**Please print and check one:** ☐ MD, ☐ DO, ☐ NP, ☐ PA)			Date __ __ / __ __ / __ __ __ __
Address		Tel. (__ __ __) __ __ __ - __ __ __ __	Fax. (__ __ __) __ __ __ - __ __ __ __
NYS License # **(Required)**	E-mail	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**	

FOR PRINT USE ONLY | Confidential Information should not be sent by email.

DIABETES MEDICATION ADMINISTRATION FORM

Provider Medication Order Form – Office of School Health – School Year **2020-2021**

DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945.

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to the nurse giving my child's prescribed medicine, and the nurse/trained staff checking their blood sugar and treating their low blood sugar based on the directions and skill level determined by my child's health care practitioner. These actions may be performed on school grounds or during school trips.
2. I also consent to any equipment needed for my child's medicine being stored and used at school.
3. I understand that:
   - I must give the school nurse my child's medicine, snacks, equipment, and supplies and must replace such medicine, snacks, equipment and supplies as needed. OSH recommends the use of safety lancets and other safety needle devices and supplies to check my child's blood sugar levels and give insulin.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - 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), I authorize OSH to provide diabetes-related health services to my child. These services may include but are not limited to 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. OSH will not need my signature for future MAFs.
   - OSH and the Department of Education (DOE) are responsible for making sure that my child can safely test his or her blood sugar.
   - This form represents my consent and request for the diabetes 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.
   - For the purposes of providing care or treatment for my child, 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.

OSH Parent Hotline for questions about the Diabetes Medication Administration Form (DMAF): 718-310-2496

FOR SELF-ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- 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 them 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 them 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 Glucagon if prescribed by their health care provider if my child is temporarily unable to carry and take medicine. **This does not include nasal Glucagon as New York State does not endorse training non-licensed personnel to administer nasal Glucagon at this time.**

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

Student Last Name	**First Name**	**MI**	**Date of Birth** __ __ / __ __ / __ __ __ __

School ATSDBN/Name	**Borough**	**District**

Print Parent/Guardian's Name	**Parent/Guardian's Signature for Parts A & B**	**Date Signed**
	SIGN HERE	__ __ / __ __ / __ __ __ __

Parent/Guardian's Email

Parent/Guardian's Address

Telephone Numbers: **Daytime** (__ __ __) __ __ __-__ __ __ __ **Home** (__ __ __) __ __ __-__ __ __ __ **Cell Phone** (__ __ __) __ __ __-__ __ __ __

Alternate Emergency Contact's Name	**Relationship to Student**	**Contact Telephone Number**
		(__ __ __) __ __ __-__ __ __ __

DIABETES MEDICATION ADMINISTRATION FORM

Provider Medication Order Form – Office of School Health – School Year **2020-2021**

DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945.

For Office of School Health (OSH) Use Only

OSIS Number:

Received by: Date _ _/_ _/_ _ _ _

Reviewed by: 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

Notes:

Attach student photo here

GENERAL MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR SEIZURE, ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name	First Name	Middle	**Date of birth** _ _ / _ _ / _ _ _ _ (MM DD YYYY)	☐ Male ☐ Female

OSIS Number _ _ _ _ _ _ _ _ _ _ _ _

School (include ATSDBN/name, address and borough)	**DOE District**	**Grade**	**Class**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

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

Medication: _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level *(Select the most appropriate option):*

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

Initial below for Independent (Not allowed for controlled substances)

Practitioner's Initials: _____

I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

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: _____

Student Skill Level *(Select the most appropriate option):*

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

Initial below for Independent (Not allowed for controlled substances)

Practitioner's Initials: _____

I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

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: _____

Student Skill Level *(Select the most appropriate option):*

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

Initial below for Independent (Not allowed for controlled substances)

Practitioner's Initials: _____

I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

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)

Health Care Practitioner Name LAST FIRST (**Please print and circle one:** MD, DO, NP, PA)	Signature	Date _ _ / _ _ / _ _ _ _
Address	Tel. (_ _ _) _ _ _ - _ _ _ _	Fax. (_ _ _) _ _ _ - _ _ _ _
NYS License # **(Required)** / NPI # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _		

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 ➔

GENERAL MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR SEIZURE, ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st 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.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box.** I will Provide the school with current, unexpired medicine for my child's use during school days
     - 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**.**
   - **No student is allowed to carry or give him or herself controlled substances.**
   - The Office of School Health (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), OSH may provide health services to my child. These services may include but are not limited to 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. OSH will not need my signature for future MAFs.
   - This form represents my consent and request for the medication 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.
   - For the purposes of providing care or treatment to my child, 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.

FOR SELF-ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- 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.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __
School ATSDBN/Name	Borough		District
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	**Relationship to Student**	**Contact Telephone Number** (__ __ __) __ __ __ - __ __ __ __

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

*Confidential Information should not be sent by email

FOR PRINT USE ONLY

Attach student photo here

REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name	First Name	Middle	**Date of birth** __ __ / __ __ / __ __ __ __ M M D D Y Y Y Y	☐ Male ☐ Female

OSIS Number __ __ __ __ __ __ __ __ __

School (include ATSDBN/name, address and borough)	**DOE District**	**Grade**	**Class**

HEALTHCARE PRACTITIONERS COMPLETE BELOW

ONE ORDER PER FORM (make copies of this from for additional orders). Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization.

- ☐ Clean Intermittent Catheterization Cath Size _____Fr.
- ☐ Central Venous Line
- ☐ G-Tube Feeding*: ☐ Bolus ☐ Pump ☐ Gravity Cath Size _____Fr.
- ☐ J-Tube Feeding*: ☐ Bolus ☐ Pump ☐ Gravity Cath Size _____Fr.
- ☐ Naso-Gastric Feeding* Cath Size _____Fr.
- ☐ Specialized/Non-Standard Feeding* Cath Size _____Fr.
- ☐ Feeding Tube replacement if dislodged - specify in area below
- ☐ Oral / Pharyngeal Suctioning Cath Size _____Fr.
- ☐ Tracheostomy Care Trach. Size _____.
- ☐ Trach. suctioning Cath. Size _____Fr.
- ☐ Trach replacement - specify in area below
- ☐ Oxygen Administration - specify in area below
- ☐ Pulse Oximetry monitoring
- ☐ Vagus Nerve Stimulator
- ☐ Other: _____
- ☐ Ostomy Care
- ☐ Chest Clapping
- ☐ Percussion
- ☐ Postural Drainage
- ☐ Dressing Change

Student will also require treatment: ☐ during transport ☐ on school-sponsored trips ☐ during afterschool programs

Student Skill Level *(Select the most appropriate option)*:

- □ Nurse-Dependent Student: nurse must administer treatment
- □ Supervised Student: student self-treats under adult supervision
- □ Independent Student: student is self-carry/self-treat *(initial below)*

☐ I attest student demonstrated the ability to self-administer the prescribed treatment effectively for school/field trips/school-sponsored events

Practitioner's initials

1. Diagnosis: Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS)
   ☐ _ _ _ . _ _ _ ☐ _ _ _ . _ _ _ ☐ _ _ _ . _ _ _

   Diagnosis is self- limited ☐ Yes ☐ No

2. Treatment required in school:
   - □ Feeding: _____ _____ _____ _____ _____ _____
     Formula Name | Concentration | Route | Amount/Rate | Duration | Frequency/specific time(s) of administration

*** Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.**

- □ Flush with ____ mL _____ ☐ before feeding ☐ after feeding
- □ Oxygen administration: _____ _____ □ _____ □ prn □ O2 Sat < _____% □ _____
  Amount (L) | Route | Frequency/specific time(s) of administration | Specify Symptoms
- □ Other Treatment: _____ _____ □_____ □ prn _____
  Treatment Name | Route | Frequency/specific time(s) of administration | Specify Symptoms
- □ Additional Instructions or Treatment:

3. Conditions under which treatment should not be provided:

4. Possible side effects/adverse reactions to treatment:

5. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions, including dislodgement or blockage of tracheostomy or feeding tube:

6. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:

7. Date(s) when treatment should be: Initiated __ __ / __ __ / __ __ __ __ Terminated __ __ / __ __ / __ __ __ __

Health Care Practitioner LAST NAME (**Please Print and circle one:** MD, DO, NP, PA)	FIRST NAME	Signature
Address	Tel. No. (__ __ __) __ __ __ - __ __ __ __	Fax. No (__ __ __) __ __ __ - __ __ __ __
E-mail address	Cell phone (__ __ __) __ __ __ - __ __ __ __	
NYS License No **(Required)** ___ ___ ___ ___ ___ ___	NPI No. __ __ __ __ __ __ __ __ __ __	Date __ __ / __ __ / __ __ __ __

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 4/20 **PARENTS MUST SIGN PAGE 2 ➔**

REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

PARENT/GUARDIAN FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medical supplies, equipment and prescribed treatments being stored and given at school based on directions from my child's health care practitioner.
2. I understand that:
   - I must give the school nurse my child's medical supplies, equipment and treatments.
   - **All supplies I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired supplies for my child's use during school days.**
     - Supplies, equipment and treatments should be labeled with my child's name and date of birth.
   - I must **immediately** tell the school nurse about any change in my child's treatments or the health care practitioner's instructions.
   - The Office of School Health (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 form, I authorize OSH to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The treatment instructions/orders on this form expire at the end of my child's school year, which may include the summer session, or when I give the school nurse a new form (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. OSH will not need my signature for future MAFs.
   - This form represents my consent and request for the medical 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.
   - For the purposes of providing care or treatment to my child, 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.

FOR SELF-TREATMENT (INDEPENDENT STUDENTS ONLY)

- I certify/confirm that my child has been fully trained and can perform treatments on his or her own. I consent to my child carrying, storing and giving him or herself the treatments prescribed on this form in school. I am responsible for giving my child these supplies and equipment labeled as described above. I am also responsible for monitoring my child's treatments, and for all results of my child's self-treatment in school. The school nurse will confirm my child's ability to perform treatments on his/her own. I also agree to give the school clearly labeled "back up" equipment or supplies in the event that my child is unable to self-treat.

Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __	School
School ATSDBN/Name			Borough	District
Parent/Guardian's Name (Print)			**Parent/Guardian's Signature** SIGN HERE	**Date Signed** __ __ / __ __ / __ __ __ __
Parent/Guardian's Email			**Parent/Guardian's Address**	

Telephone Numbers:

Daytime (__ __ __) __ __ __ - __ __ __ __ **Home** (__ __ __) __ __ __ - __ __ __ __ **Cell Phone*** (__ __ __) __ __ __ - __ __ __ __

Alternate Emergency Contact's Name	**Relationship to Student**	**Alternate Contact's Telephone Number** (__ __ __) __ __ __ - __ __ __ __

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

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

FOR PRINT USE ONLY

Attach student photo here

SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

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**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis/Seizure Type:

☐ Localization related (focal) epilepsy ☐ Primary generalized ☐ Secondary generalized ☐ Childhood/juvenile absence
☐ Myoclonic ☐ Infantile spasms ☐ Non-convulsive seizures ☐ Other (please describe)

Seizure Type	Duration	Frequency	Description	Triggers/Warning Signs

Post-ictal presentation:

Seizure/Status Epilepticus History: Describe history & most recent episode (date, trigger, pattern, duration, treatment, hospitalization, ED visits, etc.):

Has student had surgery for epilepsy? ☐ No ☐ Yes

TREATMENT PROTOCOL DURING SCHOOL:

A. In-School Medications

Student Skill Level *(select the most appropriate option)*

☐ Nurse-Dependent Student: nurse/nurse-trained staff must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer
I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

Name of Medication	Concentration/ Formulation	Dose	Route	Frequency or Time	Side Effects/Specific Instructions

B. Does student have a Vagal Nerve Stimulator (VNS)? *(any trained adult can administer)* ☐ **No** ☐ **Yes, If YES, describe magnet use:**
Swipe magnet ☐ immediately ☐ within ____ min; if seizure continues, repeat after _____ min ____ times;
Give emergency medication after _____min and call 911

C. Emergency Medication(s) (list in order of administration) *[Nurse must administer]* ; CALL 911 immediately after administration

Name of Medication	Concentration/ Preparation	Dose	Route	Administer Within	Side Effects/Special Instructions
				min	
				min	

ACTIVITIES:

Adaptive/protective equipment (e.g. helmet) used? ☐ No ☐ Yes If YES, please describe:
Gym/physical activity participation restrictions? ☐ Yes ☐ No If YES, please describe:
☐ No contact sports ☐ 1:1 for swimming ☐ Harness for climbing ☐ Field trips
☐ **Other:**_____

504 accommodations requested? ☐ Yes (*attach form*) ☐ No

Home Medication(s)	Dosage, Route, Directions	Side Effects/Special Instructions

Other special instructions:

Health Care Practitioner LAST NAME (**Please print and check one:** ☐ MD, ☐ DO, ☐ NP, ☐ PA)	FIRST NAME	Signature
Address	Tel. No. (__ __ __) __ __ __ - __ __ __ __	Fax. No (__ __ __) __ __ __ - __ __ __ __
E-mail address	Cell phone (__ __ __) __ __ __ - __ __ __ __	
NYS License No **(Required)** __ __ __ __ __ __ __ __	NPI No. __ __ __ __ __ __ __ __ __ __	Date __ __ / __ __ / __ __ __ __

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 ➔

SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st 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.
   - **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**.**
   - **No student is allowed to carry or give him or herself controlled substances.**
   - The Office of School Health (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), 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. OSH will not need my signature for future MAFs.
   - This form represents my consent and request for the medication 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 (Non-Emergency Medications):

- 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.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __
School Name/Number	Borough		District
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	**Relationship to Student**	**Contact Telephone Number** (__ __ __) __ __ __ - __ __ __ __

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

*Confidential Information should not be sent by email