

# MEDICATION ADMINISTRATION FORM

**THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS**  
 Provider Medication Order Form | Office of School Health | School Year **2018-2019**  
**DUE: JULY 15<sup>th</sup>. Forms submitted after July 15<sup>th</sup> may delay processing for new school year.**

Attach student photo here

Student Last Name _____	First Name _____	Middle _____	Date of birth ____/____/____ MM DD YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
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OSIS Number _____	School (include name, number, address and borough) _____	DOE District _____	Grade _____	Class _____
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## 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  
 (NOT ALLOWED FOR CONTROLLED SUBSTANCES)

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

**Practitioner's Initials**

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

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

**Practitioner's Initials**

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  
 (NOT ALLOWED FOR CONTROLLED SUBSTANCES)

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

**Practitioner's Initials**

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

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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.
  - **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).
  - 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:**

- 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.

**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
Print Parent/Guardian's Name			<b>SIGN HERE</b> →	
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 (for supervised students only) <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	