ALLERGIES / ANAPHYLAXIS

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2015–2016

1` ATTACH STUDENT PHOTO HERE	Student Last Name / First Name / Middle	Date of birth __/__/____ MM DD YYYY	Weight (kg) ____.__	☐ Male ☐ Female
		OSIS # ___ ___ ___ ___ ___ ___		
	School (include name, number, address and borough)	DOE District ___ ___	Grade	Class

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

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	☐ Yes	☐ No
If yes, symptoms	☐ Respiratory	☐ Skin	☐ GI	☐ Cardiovascular	☐ Neurologic		Recognize signs of allergic reactions	☐ Yes	☐ No
Treatment	Date __/__/____						Recognize/avoid allergens independently	☐ Yes	☐ No
History of skin testing?	☐ Yes (attach copy of results) Date __/__/____					☐ No	Comments:		

Select In School Medications

1. ONLY SINGLE DOSE AUTO-INJECTORS SELECT BELOW

☐ Epinephrine Auto-Injector 0.15 mg/0.3 ml

☐ Epinephrine Auto-Injector 0.3 mg/0.3 ml

☐ Give antihistamine in addition to epinephrine **(must order antihistamine below)**

Choose all options that are appropriate:

☐ **Student** may carry medication and may self-administer **(INCLUDES SCHOOL TRIPS &/OR AFTER-SCHOOL PROGRAMS)** (PARENT MUST INITIAL REVERSE SIDE)

☐ Medication should be kept in close proximity to student; choose option:

- ☐ **Student** to self-administer (PARENT MUST INITIAL REVERSE SIDE).
- ☐ **Nurse** or **trained staff** to administer

In School Instructions

PRN (check all that apply):

☐ Itching ☐ Hives ☐ Swelling ☐ Redness

☐ Shortness of Breath ☐ Tightness / Closure ☐ Hoarseness ☐ Wheezing

☐ Vomiting / Diarrhea ☐ Weak Pulse ☐ Pallor / Cyanosis ☐ Dizziness / Fainting

Specify signs, symptoms, or situations:

- ➢ Administer Intramuscularly into anterolateral aspect of thigh
- ➢ **Call 911 immediately**

If no improvement, repeat in ___ minutes for a maximum of __ times (not to exceed a total of 3 doses).

2. ORAL MEDICATION: ☐ **Diphenhydramine**

Preparation/Concentration: _____

Route: _____

Choose all options that are appropriate:

☐ **Student** may carry medication and may self-administer **(INCLUDES SCHOOL TRIPS &/OR AFTER-SCHOOL PROGRAMS)** (PARENT MUST INITIAL REVERSE SIDE)

☐ Medication should be kept in close proximity to student; choose option:

- ☐ **Student** to self-administer (PARENT MUST INITIAL REVERSE SIDE).
- ☐ **Nurse** to administer

PRN (check all that apply):

☐ Itchy / Runny Nose ☐ Sneezing

☐ Itchy Mouth ☐ Mildly Itchy Skin

☐ Few Hives ☐ Mild Nausea / Discomfort

Specify signs, symptoms, or situations:

Dose: _____ q ☐ **4 hours or** ☐ **6 hours as needed (specify)**

If no improvement, indicate instructions:

3. ORAL MEDICATION: _____

Preparation/Concentration: _____

Route: _____

Choose all options that are appropriate:

☐ **Student** may carry medication and may self-administer **(INCLUDES SCHOOL TRIPS &/OR AFTER-SCHOOL PROGRAMS)** (PARENT MUST INITIAL REVERSE SIDE)

☐ Medication should be kept in close proximity to student; choose option:

- ☐ **Student** to self-administer (PARENT MUST INITIAL REVERSE SIDE).
- ☐ **Nurse** to administer

PRN *Specify signs, symptoms, or situations:*

Dose: _____ **Time interval:** q __ (specify min or hours)

Conditions under which medication should not be given:

If no improvement, indicate instructions:

HOME Medications (include over-the counter)	For DOHMH Only
	Revisions per DOHMH after consultation with prescribing provider. ☐ IEP

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

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

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

Rev 4/15

ALLERGIES / ANAPHYLAXIS

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2015–2016

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __	School

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the school nurse and the principal and/or his/her designee(s) of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this Authorization is only valid until the earlier of: (1) June 30, 2016 (This prescription may be extended through August if the student is attending a New York City Department of Education ("DOE") sponsored summer instruction program); or (2) such time that I deliver to the school nurse and the principal and/or his/her designee(s) a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed medication. By submitting this MAF, I am requesting that my child be provided with specific health services by DOE and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH"). I understand that part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this MAF. I further understand that the OSH, DOE and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize OSH and DOE and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

****SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications):**

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize OSH and DOE, their agents and employees; including the school nurse, principal, his/her designee(s), and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

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

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

You must send your child's epinephrine, asthma inhaler and other approved self-administered medications with your child on a school trip day and/or after-school programs in order that he/she has it available.

Parent/Guardian's Signature	Print Parent/Guardian's Name
Date Signed __/__/____	Parent/Guardian's Address

Telephone Numbers: **Daytime** (___)___-____ **Home** (___)___-____ **Cell Phone*** (___)___-____

Parent/Guardian e-mail address*

Alternate Emergency Contact's Name	Contact Telephone Number (___)___-____

DO NOT WRITE BELOW – FOR DOE AND DOHMH ONLY

Received by: Name	Date __/__/____	Reviewed by: Name	Date __/__/____

Self-Administers/Self-Carries: ☐ Yes ☐ No

Services provided by: ☐ Nurse ☐ DOHMH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff

Signature and Title (RN OR MD):

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