CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | **First Name** | **Middle Name** | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* ___/___/____

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | **State** | **Zip Code** | **School/Center/Camp Name** | **District** __ __ **Number** __ __ __

Phone Numbers Home _____ Cell _____ Work _____

Health Insurance (including Medicaid)? ☐ Yes ☐ No

☐ Parent/Guardian **Last Name** **First Name**

☐ Foster Parent

Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

PHYSICAL EXAM **Date of Exam:** ___/___/____

Height _____ cm (___ ___ %ile)

Weight _____ kg (___ ___ %ile)

BMI _____ kg/m² (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ cm (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____/_____

General Appearance:

☐ Physical Exam WNL

	NI	Abnl
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No **Date Screened** ___/___/____

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
Child Care Only		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ NI ☐ Abnl ☐ Referred
OAE	___/___/___	☐ NI ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ NI ☐ Abnl ☐ Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ NI ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay ☐ Yes ☐ No

Urgent need for dental referral *(pain, swelling, infection)* ☐ Yes ☐ No

Dental Visit within the past 12 months ☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Tdap	___/___/___	___/___/___	
MMR	___/___/___	___/___/___	
Varicella	___/___/___	___/___/___	
Mening ACWY	___/___/___	___/___/___	
Hep A	___/___/___	___/___/___	
Rotavirus	___/___/___	___/___/___	
Mening B	___/___/___	___/___/___	
Other _____	___/___/___	___/___/___	

Report only positive immunity:

	IgG Titers	Date
Hepatitis B		___/___/___
Measles		___/___/___
Mumps		___/___/___
Rubella		___/___/___
Varicella		___/___/___
Polio 1		___/___/___
Polio 2		___/___/___
Polio 3		___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

_____ _____

_____ _____

_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature

Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)*

Practitioner License No. and State

Facility Name

National Provider Identifier (NPI)

Address City State Zip

Telephone Fax Email

DOHMH ONLY **PRACTITIONER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

FORM ID#

Cathedral High School

350 East 56th Street | New York, NY 10022
Phone: (212) 688-1545 | Fax: (212) 754-2024
www.cathedralhs.org

2021-2022 School Year Immunization Requirement for Meningococcal Vaccine

IMPORTANT: On June 13, 2019, NYS eliminated the religious exemption from vaccinations for school attendance. Information is available on the NYS Department of Health website at:
https://www.health.ny.gov/prevention/immunization/schools

March 2021

Dear Parent/Guardian,

All 7th, 8th, 9th, 10th and 12th grade students MUST HAVE proof of having been given Meningococcal vaccine (shot) in order to attend school.

- Students entering Grade 7, 8, 9, and 10 in 2021-2022 must have 1 does of meningococcal vaccine. They will be required to get a booster at age 16.
- Students entering Grades 12 in 2021-2022 must have either:
  - 2 doses of meningococcal vaccine with the booster dose given on or after age 16
  - 1 dose if your child's first does was given on or after age 16

New York State law requires parents/guardians to give the school an immunization (shot) record that show their child has received, or has appointment(s) to receive the required vaccine(s) (shots) in order to attend school. This record may be from a health care provider, health department, or an official immunization record from the child's former school. The record must include:

1. Name of the vaccine
2. Date vaccine give
3. Who gave it, along with their title; or where it was given if at a clinic

Please contact your health provider to make sure your child has what they need to attend school this fall.

If you have questions/concerns about immunizations, please contact your healthcare provider.

School Contact Information

Assistant Principal: Rosemary Eivers
School: Cathedral High School
Phone: (212) 688-1545
Fax: (212) 754-2024
Email: reivers@cathedralhs.org

NYC | Department of Health and Mental Hygiene | Department of Education

Dear Parent/Guardian,

As of June 13, 2019, public, private and parochial schools and child care programs in New York can no longer accept requests for religious exemptions from school immunization requirements. This law applies to students in pre-kindergarten through 12th grade and to all child care settings. If you previously obtained a religious exemption for your child, it is no longer valid. Schools and child care programs will continue to accept medical exemptions.

Students must meet immunization requirements in order to attend school. Children who did not attend school or child care over the summer who have not received all required immunizations must receive the first dose in each immunization series by September 19, 2020. By October 7, 2020, parents or guardians of such children will also need to show that they have scheduled appointments for all follow-up doses. Children who do not meet immunization requirements will not be permitted to remain in school.

A list of the new school immunization requirements for the 2020-21 school year is summarized below.

All students in child care through grade 12 must meet the requirements for the following vaccines:

- DTaP (diphtheria, tetanus and acellular pertussis or whooping cough)
- Poliovirus
- MMR (measles, mumps and rubella)
- Varicella (chickenpox)
- Hepatitis B

Children under age 5 who are enrolled in child care and pre-kindergarten must also meet the requirements for these vaccines:

- Hib (*Haemophilus influenza* type b)
- PCV (pneumococcal disease)
- Influenza (flu): Children must receive the flu vaccine by December 31, 2020

Children in grades 6 through 12 must also meet the requirements for these vaccines:

- Tdap booster (tetanus, diphtheria and pertussis)
- MenACWY (meningococcal disease)

Please review your child's immunization history with their health care provider. Their provider can tell you whether additional doses of one or more vaccines are required for your child to attend or remain in child care or school. Visit schools.nyc.gov and search for "immunizations" for a full list of required vaccines.

If you have questions about these requirements, please contact your child care center or school's administrative office.

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 History of	Y ☐ N ☐ U ☐	____ times
asthma-related hospitalizations within past 12 months History of	Y ☐ N ☐ U ☐	____ times
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 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

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** __/__/____ MM DD YYYY	☐ 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	Signature	
(Please print and circle one: MD, DO, NP, PA)			Date __/__/____
Address			
NYS License # **(Required)**	NPI #	Tel. (___)___-____	Fax. (___)___-____

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
School ATSDBN/Name			Borough Select 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

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