NOTE: Parent signature required on reverse side of this form. Current photograph of student MUST be attached to upper left corner of this form.

MEDICATION ADMINISTRATION FORM

Authorization for Administration of Medication to Students for School Year 2011–2012

Student's Name *(Last, First, Middle)*	Male ☐ Female ☐	Date of Birth	I.D. Number

DOE District	School (PS, IS, etc. and Name)	Grade	Class	Borough

School Address	Zip Code

1. **Diagnosis ASTHMA** ☐ **Yes** ☐ **No**	***Choose all that apply***	***Instructions for lack of improvement or adverse reaction***	***Choose all that are appropriate***
Choose Severity: ☐ **Intermittent** ☐ **Moderate Persistent*** ☐ **Mild Persistent*** ☐ **Severe Persistent*** ***National guidelines recommend inhaled corticosteroids for children with persistent asthma.** **Stock supply only available for Ventolin HFA.** ***(see back)*** **Choose One:** ☐ **Ventolin HFA (may be provided by school for shared usage).** ☐ _____ **HFA (to be provided by parent).** ADD MEDICATION NAME ◯ **May substitute stock ventolin** ◯ **May not substitute stock ventolin** **INDICATE HOME MEDS IN BOTTOM LEFT BOX.**	☐ **Standard order**. 2 puffs q 4 hrs. via MDI and spacer prn cough, wheeze, tightness in chest, difficulty breathing or shortness of breath. May repeat in 15 mins x 2 if no improvement (3 total). ☐ **Pre exercise**. 2 puffs via MDI with spacer 15-30 minutes before exercise. ☐ **URI or recent asthma flare** (within 3 days). 2 puffs @ noon via MDI inhaler and spacer for 3-5 days.	If improved, but not enough to return to class, call parent. If significant respiratory distress persists, call 911 and notify parent and PMD. May provide additional puffs as needed until EMS arrives.	☐ Student may carry medication and may self-administer. ***(PARENT MUST INITIAL REVERSE SIDE).*** ☐ Store medication in medical room and student to self-administer under observation. ☐ Store medication in medical room and nurse to administer. ☐ Can this student self administer their personal MDI on school trips. Check one: ☐ Yes ☐ No
2. **Diagnosis: Anaphylaxis** **Select One:** ☐ EpiPen Auto-Injector: 0.3 mg/0.3 ml [1:1000] ☐ EpiPen Jr. Auto-Injector: 0.15 mg/0.3 ml [1:2000] Intramuscularly into anterolateral aspect of thigh 911 will be called immediately	☐ **prn** _____ ***specific signs, symptoms or situations*** **Any repeats if no improvement?** ☐ **Yes, in** ____ **mins, max** ____ **times**	Conditions under which medication should not be given: _____ _____ _____	☐ Student may carry medication (includes epi pen and MDI) and may self-administer. ***(PARENT MUST INITIAL REVERSE SIDE).*** NOT FOR CONTROLLED SUBSTANCES. ☐ Store medication in medical room and student to self-administer under observation. ☐ Store medication in medical room and nurse to administer.
3. **Diagnosis** _____ _____ Medication/Preparation/Concentration _____ Dose/Route ☐ Diagnosis substantially controlled with medication. ☐ Diagnosis not substantially controlled with medication.	☐ **Standing daily dose. Specify time(s):** _____ ***AND/OR*** ☐ **prn** _____ ***specific signs, symptoms or situations*** **Time interval: q** _____ **hours as needed** **Any repeats if no improvement?** ☐ **Yes, in** ____ **hr/mins, max** ____ **times**	Conditions under which medication should not be given: _____ _____ _____	☐ Student may carry medication (includes epi pen and MDI) and may self-administer. ***(PARENT MUST INITIAL REVERSE SIDE).*** NOT FOR CONTROLLED SUBSTANCES. ☐ Store medication in medical room and student to self-administer under observation. ☐ Store medication in medical room and nurse to administer.

List medication(s) student takes at home and at what time:

_____

_____

_____

Health Care Practitioner (HCP) Name (PLEASE PRINT) LAST NAME	FIRST NAME	HCP Signature

HCP/Clinic Address

HCP/Clinic Tel. No.	HCP/Clinic Fax No.	NYS Registration No. (Required)	Date

FOR DOHMH USE: Revisions per DOHMH after consultation with prescribing provider

☐ **IEP**

_____

_____

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

MEDICATION ADMINISTRATION FORM (MAF): PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION
2011-2012

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 principal and/or his/her designee(s) especially the school nurse 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 29, 2012 (This prescription may be extended through August if the student is attending a New York City Department of Education (the "Department") sponsored summer instruction program); or (2) such time that I deliver to the principal or his/her designee(s) and nurse 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 the Department 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 the Department, DOHMH 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 Department, DOHMH and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by the Department or DOHMH 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 the Department, DOHMH 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 Epi-Pen, 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 the Department, DOHMH, their agents and employees; including the principal, his/her designee(s), school nurse 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 with the school. In addition, I agree to provide "back up" medication in a clearly labeled bottle 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 **Personal Metered Dose Inhaler (MDI)** with your child on a **school trip day** in order that he/she has it available. The stock Ventolin is **only** for use while your child is in the school building.*

Please Print Parent/Guardian's Name & Address Below:

_____ _____

Parent/Guardian's Signature

_____ _____

Date Signed

_____

Daytime Telephone No. **Home Telephone No.**

(DO NOT WRITE BELOW - FOR DOE AND DOHMH ONLY)

Student's Name:_____ OSIS No: _____

Received by: _____ _____ Reviewed by: _____ _____
Name Date Name Date

Referred to School 504 Coordinator ☐ Yes ☐ No Self-Administers/Self-Carries: ☐ Yes ☐ No

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

Signature and Title:_____ _____
(RN OR MD) (Date school notified and form forwarded to DOE Liaison)