Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2018–2019**

DUE: JULY 15th. Forms submitted after July 15th 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 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
History of allergy testing?	☐ Yes *(attach copy of results)* Date __ __ / __ __ / __ __ __ __	☐ No	Comments:		

Select In School Medications

1. SEVERE REACTION

- **CALL 911**, Immediately administer:

☐ **Epinephrine** Auto-Injector 0.15 mg

☐ **Epinephrine** Auto-Injector 0.3 mg (retractable devices preferred) intramuscularly into the anterolateral of thigh for the following symptoms:

- 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**.

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

Student Skill Level *(select the most appropriate option)*	**Practitioner's Initials**	
☐ 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.

2. MILD REACTION:

- Give antihistamine: Name:_____Preparation/Concentration:_____ Dose:_____ Route: _____
  Frequency: ☐ **Q4** hours **or** ☐ **Q6** hours as needed for the following symptoms:
  - Itchy nose, sneezing, itchy mouth
  - A few hives
  - Mild stomach nausea or discomfort
  - Other: _____
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine.

Student Skill Level *(select the most appropriate option)*	**Practitioner's Initials**	
☐ 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.

3. OTHER MEDICATION (e.g., inhaler/bronchodilator if child has asthma):

- 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)*	**Practitioner's Initials**	
☐ 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.

Home Medications *(include over-the counter)*

Health Care Practitioner Name LAST FIRST (Please Print)	Signature	Date __ __ / __ __ / __ __ __ __
Address	Tel. (___) ___ - ____	Fax. (___) ___ - ____
NYS License # **(Required)**	NPI # __ __ __ __ __ __ __ __ __ __	

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

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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. 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 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.
   - 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), the Office of School Health (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 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.
   - 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.

SELF-ADMINISTRATION OF MEDICATION:

- 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.
- 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.

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
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 | **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