

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 1<sup>st</sup> may delay processing for new school year

Student Last Name	First Name	Middle	Date of birth ___/___/____ MM DD YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
OSIS Number _____	Weight _____ kg			
School (include ATSDBN/name, number, address and borough)	DOE District	Grade	Class	

## HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy <input type="checkbox"/> Allergy to	Specify Allergy <input type="checkbox"/> Allergy to	Specify Allergy <input type="checkbox"/> Allergy to
History of asthma? <input type="checkbox"/> Yes (If yes, student has an increased risk for a severe reaction) <input type="checkbox"/> No	Does this student have the ability to:	
History of anaphylaxis? <input type="checkbox"/> Yes Date ___/___/____ <input type="checkbox"/> No	Self-Manage (See 'Student Skill Level' below) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, system affected <input type="checkbox"/> Respiratory <input type="checkbox"/> Skin <input type="checkbox"/> GI <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Neurologic	Recognize signs of allergic reactions <input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment Date ___/___/____	Recognize/avoid allergens independently <input type="checkbox"/> Yes <input type="checkbox"/> 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
- Fainting or dizziness
- Lip or tongue swelling that bothers breathing
- Pale or bluish skin color
- Tight or hoarse throat
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Weak pulse
- Trouble breathing or swallowing
- Feeling of doom, confusion, altered consciousness or agitation
- Many hives or redness over body

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	Date ___/___/____
(Please print and circle one: MD, DO, NP, PA)			
Address			
NYS License # (Required)	NPI #	Tel. (____) _____	Fax. (____) _____

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## PARENTS/GUARDIANS FILL BELOW

### BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

- 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.
- 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	District
Parent/Guardian's Name (Print)			<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		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