# 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** ☐ **Foster Parent** **Last Name** **First Name** **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

| *Nl Abnl* | *Nl Abnl* | *Nl Abnl* | *Nl Abnl* | *Nl Abnl* |
|---|---|---|---|---|
| ☐ ☐ Psychosocial Development | ☐ ☐ HEENT | ☐ ☐ Lymph nodes | ☐ ☐ Abdomen | ☐ ☐ Skin |
| ☐ ☐ Language | ☐ ☐ Dental | ☐ ☐ Lungs | ☐ ☐ Genitourinary | ☐ ☐ Neurological |
| ☐ ☐ Behavioral | ☐ ☐ Neck | ☐ ☐ Cardiovascular | ☐ ☐ Extremities | ☐ ☐ 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 | ___/___/___ | ☐*Nl* ☐*Abnl* ☐*Referred* |
| OAE | ___/___/___ | ☐*Nl* ☐*Abnl* ☐*Referred* |
| ≥ 4 yrs: pure tone audiometry | ___/___/___ | ☐*Nl* ☐*Abnl* ☐*Referred* |

| **Vision** | *Date Done* | *Results* |
|---|---|---|
| <3 years: Vision appears: | ___/___/___ | ☐ *Nl* ☐ *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 ☐

Report only positive immunity:

**IMMUNIZATIONS – DATES**

| | | | | | | | | | | | | | | | IgG Titers | Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DTP/DTaP/DT | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | | | Tdap | ___/___/___ | ___/___/___ | | | Hepatitis B | ___/___/___ |
| Td | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | | | MMR | ___/___/___ | ___/___/___ | | | Measles | ___/___/___ |
| Polio | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | | | Varicella | ___/___/___ | ___/___/___ | | | Mumps | ___/___/___ |
| Hep B | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | | | Mening ACWY | ___/___/___ | ___/___/___ | | | Rubella | ___/___/___ |
| Hib | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | | | Hep A | ___/___/___ | ___/___/___ | | | Varicella | ___/___/___ |
| PCV | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | | | Rotavirus | ___/___/___ | ___/___/___ | | | Polio 1 | ___/___/___ |
| Influenza | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | | | Mening B | ___/___/___ | ___/___/___ | | | Polio 2 | ___/___/___ |
| HPV | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | | | Other _____ | ___/___/___ | _____ ___/___/___ | | | 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#**

# 2020-21 School Year
# New York State Immunization Requirements for School Entrance/Attendance[1]

**NOTES:**
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

**Dose requirements MUST be read with the footnotes of this schedule**

| Vaccines | Prekindergarten (Day Care, Head Start, Nursery or Pre-k) | Kindergarten and Grades 1, 2, 3, 4 and 5 | Grades 6, 7, 8, 9, 10 and 11 | Grade 12 |
|---|---|---|---|---|
| **Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]** | **4 doses** | **5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older | **3 doses** | |
| **Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]** | **Not applicable** | | **1 dose** | |
| **Polio vaccine (IPV/OPV)[4]** | **3 doses** | **4 doses or 3 doses** if the 3rd dose was received at 4 years or older | | |
| **Measles, Mumps and Rubella vaccine (MMR)[5]** | **1 dose** | **2 doses** | | |
| **Hepatitis B vaccine[6]** | **3 doses** | **3 doses or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years | | |
| **Varicella (Chickenpox) vaccine[7]** | **1 dose** | **2 doses** | | |
| **Meningococcal conjugate vaccine (MenACWY)[8]** | **Not applicable** | | **Grades 7, 8, 9, 10 and 11: 1 dose** | **2 doses or 1 dose** if the dose was received at 16 years or older |
| **Haemophilus influenzae type b conjugate vaccine (Hib)[9]** | **1 to 4 doses** | **Not applicable** | | |
| **Pneumococcal Conjugate vaccine (PCV)[10]** | **1 to 4 doses** | **Not applicable** | | |

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.

   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.

   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grade 6: 10 years; minimum age for grades 7 through 12: 7 years)

   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.

   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2020-2021, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grade 6; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 7 through 12.

   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

   d. Only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine

   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).

   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grade 7: 10 years; minimum age for grades 8 through 12: 6 weeks).

   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8, 9, 10 and 11.

   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

   d. If dose 1 was received at 15 months or older, only 1 dose is required.

   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

   d. If one dose of vaccine was received at 24 months or older, no further doses are required.

   e. PCV is not required for children 5 years or older.

   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

**New York State Department of Health**
**Bureau of Immunization**
**Room 649, Corning Tower ESP**
**Albany, NY 12237**
**(518) 473-4437**

**New York City Department of Health and Mental Hygiene**
**Program Support Unit, Bureau of Immunization,**
**42-09 28th Street, 5th floor**
**Long Island City, NY 11101**
**(347) 396-2433**

# MEDICAL REQUEST FOR IMMUNIZATION EXEMPTION

## Instructions for the Requesting Physician

This form must be completed by a NYS-licensed physician. The exemption must be based Advisory Committee on Immunization Practices guidelines. Medical exemptions are granted for no more than one year and must be renewed at the start of each school-year. Department of Health physicians may request additional information.

The following are **NOT** valid contraindications to **ANY** routine vaccine:

- Egg allergy, even if anaphylactic, is not a valid contraindication to MMR, influenza, or any other vaccine.
- Autism and/or developmental delay in the child or family member.
- Contact with immunosuppressed persons by a healthy individual.
- Pregnancy in the household or contact with a pregnant woman.

## Medical Exemption Request

As the student's physician, I request a medical exemption for (**student name**) _____ for the following required immunization(s). I certify that the particular immunization(s) will be detrimental to the child's health:

| | | | | | | For children up to the 5th birthday | | |
|---|---|---|---|---|---|---|---|---|
| ☐ Hepatitis B | ☐ DTaP/Tdap/Td | ☐ Polio | ☐ MMR | ☐ Varicella | ☐ MenACWY | ☐ PCV13 | ☐ Hib | ☐ Influenza |

**Explanation for exemption request for each vaccine (if more than one)**

Include diagnosis and/or treatment precluding vaccination, date of event, expected duration of contraindication:

_____

_____

_____

_____

_____

_____

| | | |
|---|---|---|
| **Physician Name:** | **NYS License # NY** __ __ __ __ __ __ | |
| **Physician Signature:** | **Degree (MD/DO):** (sel | **Date** __ __ / __ __ / __ __ __ __ |
| **Office Phone** ( __ __ __ ) __ __ __ - __ __ __ __ Ext __ __ __ __<br>**Cell Phone** ( __ __ __ ) __ __ __ - __ __ __ __ | | **Stamp** |

## Parent/Guardian Consent for Release of Information

I, (**parent/guardian name**)_____ authorize (**physician name**)_____ to provide physicians and nurses of the New York City Departments of Health and Mental Hygiene and Education and their medical consultants with information contained in my child's medical record, including, but not limited to copies of laboratory and or other examinations supporting this request for medical exemption for required immunizations.

**Parent/Guardian's signature** _____**Date** __ __ / __ __ / __ __ __ __

| For school/facility use | DOE Sites | Non-DOE sites |
|---|---|---|
| Student Name: | OSIS # | Facility Name: |
| Date of Birth __ __ / __ __ / __ __ __ __ | ATS DBN | Facility Contact info: |

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): _____

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. (__ __ __) __ __ __ - __ __ __ __ |

# 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

FOR PRINT USE ONLY

Attach student photo here

# DIABETES MEDICATION ADMINISTRATION FORM [PART A]

Provider Medication Order Form – Office of School Health – School Year **2020-2021**

**DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945.**

| **Student** Last Name | First Name | MI | **Date of birth** | ☐ Male ☐ Female | **OSIS #** |
|---|---|---|---|---|---|
| **School** (include ATSDBN/name, address and borough) | | | **DOE District** | **Grade** | **Class** |

## HEALTH CARE PRACTITIONER COMPLETES BELOW *[Please see 'Provider Guidelines for DMAF Completion']*

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Non-Type 1/Type 2 Diabetes ☐ Other Diagnosis: _____

Recent A1C: Date ____/____/_____ Result ____.____%

**Orders written will be for Sept. '20 through Aug '21 school year unless checked here:** ☐ Current School Year '19-'20 and '20-'21

## EMERGENCY ORDERS

**Severe Hypoglycemia**

Administer **Glucagon** and **call 911**

**Glucagon:** ☐ 1 mg ☐ ____ mg SC/IM

**GVOKE:** ☐ 1 mg ☐ ____mg SC/IM

**Baqsimi**: ☐ 3 mg Intranasal

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration.

**Risk for Ketones or Diabetic Ketoacidosis (DKA)**

☐ Test **ketones** if bG >____ mg/dl, or if vomiting, or fever > 100.5F

**OR**

☐ Test ketones if bG >____ mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5F

- If small or trace give water; re-test ketones & bG in 2 hrs or ___ hrs
- If ketones are moderate or large, give water:
  Call parent and Endocrinologist; ☐ **NO GYM**
  If ketones and vomiting, unable to take PO and MD not available, **CALL 911**

☐ Give insulin correction dose if > 2 hrs or ____ hours since last insulin.

## SKILL LEVEL

**Blood Glucose (bG) Monitoring Skill Level**

☐ Nurse / adult must check bG.

☐ Student to check bG with adult supervision.

☐ Student may check bG without supervision.

**Insulin Administration Skill Level**

☐ Nurse-Dependent Student: nurse must administer medication

☐ Supervised student: student self-administers, under adult supervision

☐ Independent Student: Self-carry / Self-administer *(MUST Initial attestation)*
I attest that the **independent** student demonstrated the ability to self-administer the prescribed medication effectively for school, field trips, & school/sponsored events _____ PROVIDER INITIALS

**NOTE: Trip nurse not required for supervised or independent students.**

## BLOOD GLUCOSE MONITORING *[See Part B for CGM readings]*

Specify times to test in school (must match times for treatment and/or insulin) ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

**Hypoglycemia**: *Check all boxes needed. Must include at least one treatment plan.*

☐ For bG < _____mg/dl give _____ gm rapid carbs at: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN
Repeat bG testing in 15 or ____ min. If bG still < _____mg/dl repeat carbs and retesting until bG > _____ mg/dl.

☐ For bG < _____mg/dl give _____ gm rapid carbs at: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN
Repeat bG testing in 15 or ____ min. If bG still < _____mg/dl repeat carbs and retesting until bG > _____ mg/dl.

☐ For bG < _____mg/dl pre-gym, **no gym** ☐ For bG < _____mg/dl ☐ Pre-gym; ☐ PRN; treat hypoglycemia then give snack.

☐ T2DM - no bG monitoring or insulin in school

15 gm rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz.

*Insulin is given before food unless noted here:* ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

**Mid-range Glycemia:** *Insulin is given before food unless noted here:* ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give snack before gym

**Hyperglycemia:** *Insulin is given before food unless noted here:* ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐
Snack ☐No Gym For bG >_____mg/dl ☐ Pre-gym and/or ☐ PRN

☐For bG >_____ mg/dl PRN, Give insulin correction dose if > 2 hrs or ____ hrs. since last insulin For bG meter reading "**High**" use bG of 500 or____ mg/dl.

☐**Check bG or Sensor Glucose (sG) before dismissal**

☐ Give correction dose pre-meal and carb coverage after meal

☐For sG or bG values <_____mg/dl treat for hypoglycemia if needed, and give _____ gm carb snack before dismissed
☐For sG or bG values <_____mg/dl treat for hypoglycemia if needed, and do not send on bus/mass transit, parent to pick up from school.

## INSULIN ORDERS

**Name of Insulin*:**

_____

* May substitute Novolog with Humalog/Admelog

☐ No Insulin in School

☐ No Insulin at Snack

**Delivery Method**:

☐ Syringe/Pen

☐ Pump *(Brand)*:

_____

☐ Smart Pen – use pen Suggestions

**Insulin Calculation Method:**

☐ Carb coverage **ONLY** at: ☐ Breakfast ☐ Lunch ☐ Snack

☐ Correction dose **ONLY** at:☐ Breakfast ☐ Lunch ☐ Snack

☐ Carb coverage **plus** correction dose when bG > Target **AND** at least 2 hrs or ___ hrs. since last insulin at ☐ Breakfast ☐ Lunch ☐ Snack

Correction dose calculated using: ☐ ISF **or** ☐ Sliding Scale

☐ Fixed Dose *(see Other Orders)*

☐ Sliding Scale *(See Part B)*

☐ If gym/recess is immediately following lunch, subtract ___ gm carbs from lunch carb calculation.

**Insulin Calculation Directions:** *(give number, not range)*

Target bG = _____ mg/dl

Insulin Sensitivity Factor (ISF):
1 unit decreases bG by _____ mg/dl
(time:_____ to _____)
1 unit decreases bG by _____ mg/dl:
(time:_____ to _____)

*If only one ISF, time will be 8am to 4pm if not specified.*

Insulin to Carb Ratio (I:C):

Bkfast **OR** time:_____ to _____
1 unit per _____ gms carbs

Snack **OR** time: _____ to _____
1 unit per 12 gms carbs

Lunch **OR** time:_____ to _____
1 unit per _____ gms carbs

Lunch followed by gym
1 unit per _____ gms carbs

**Carb Coverage:**
# gm carb in meal / X units insulin
# gm carb in I:C

**Correction Dose using ISF:**
bG – Target bG / X units insulin
ISF

Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have ½ unit marks; unless otherwise instructed by PCP/Endocrinologist. Round DOWN to nearest 0.1 unit for pumps, unless following pump recommendations or PCP/Endocrinologist orders.

**For Pumps** - Basal Rate in school:

__:___ AM/PM to __:__ AM/PM _____ units/hr
__:___ AM/PM to __:__ AM/PM _____ units/hr
__:___ AM/PM to __:__ AM/PM _____ units/hr

☐ Student on FDA approved hybrid closed loop pump-basal rate variable per pump.

☐ Suspend/disconnect pump for gym

☐ Suspend pump for hypoglycemia not responding to treatment for _____ min.

**Additional Pump Instructions:**

☐ Follow pump recommendations for bolus dose *(if not using pump recommendations, will round down to nearest 0.1 unit)*

☐ For bG > ____ mg/dl that has not decreased in ____ hours after correction, consider pump failure and notify parents.

☐ For suspected pump failure: SUSPEND pump, give insulin by syringe or pen, and notify parents.

☐For pump failure, only give correction dose if >____ hrs since last insulin.

**INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS** **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 4/20

**HEALTH CARE PRACTITIONERS: COMPLETE 'PART B' AND SIGN ➔**

**Student Name (Last, First):** _____ **OSIS Number:**_____

# DIABETES MEDICATION ADMINISTRATION FORM [PART B]

Provider Medication Order Form – Office of School Health – School Year **2020-2021**

**DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945.**

## CONTINUOUS GLUCOSE MONITORING (CGM) ORDERS *[Please see 'Provider Guidelines for DMAF Completion']*

☐ Use CGM readings - For CGM's used to replace finger stick bG readings, only devices FDA approved for use and age may be used within the limits of the manufacturer's protocol. (sG = sensor glucose).

**Name and Model of CGM:**_____

For CGM used for insulin dosing: finger stick bG will be done when: the symptoms don't match the CGM readings; if there is some reason to doubt the sensor (i.e. for readings <70 mg/dl or sensor does not show both arrows and numbers)

☐ CGM to be used for insulin dosing and monitoring - **must be FDA approved for use and age**

**sG Monitoring** Specify times to check sensor reading ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN [*if none checked, will use bG monitoring times]*
For sG <70mg/dl check bG and follow orders on DMAF, unless otherwise ordered below.
Use CGM grid below OR ☐ See attached CGM instruction

| CGM reading | Arrows | Action ☐ use < 80 mg/dl instead of < 70 mg/dl for grid action plan |
|---|---|---|
| sG < 60 mg/dl | Any arrows | Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG. |
| sG 60-70 mg/dl | and ↓, ↓↓, ↘ or → | Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG. |
| sG 60-70 mg/dl | and ↑ , ↑↑, or ↗ | If symptomatic, treat hypoglycemia per bG hypoglycemia plan; if not symptomatic, recheck in 15-20 minutes. If still <70 mg/dl check bG. |
| sG >70 mg/dl | Any arrows | Follow bG DMAF orders for insulin dosing |
| sG ≤ 120 mg/dl pre-gym or recess | and ↓, ↓↓ | Give 15 gms uncovered carbs. If gym or recess is immediately after lunch, subtract 15 gms of carbs from lunch carb calculation. |
| sG ≥ 250 | Any arrows | Follow bG DMAF orders for treatment and insulin dosing |

☐ For student using CGM, wait 2 hours after meal before testing ketones with hyperglycemia.

## PARENTAL INPUT INTO INSULIN DOSING

☐ Parent(s)/Guardian(s) (*give name*), _____, may provide the nurse with information relevant to insulin dosing, including dosing recommendations. Taking the parent's input into account, the nurse will determine the insulin dose within the range ordered by the health care practitioner and in keeping with nursing judgment.

Please select **one** option below:

**1.** ☐ Nurse may adjust calculated dose up or down up to __ units based on parental input and nursing judgment.

**2.** ☐ Nurse may adjust calculated dose up by ___% or down by ___% of the prescribed dose based on parental input and nursing judgment

**MUST COMPLETE**: **Health care practitioner can be reached for urgent dosing orders at: (_____) _____ - _____**
If the parent requests a similar adjustment for > 2 days in a row, the nurse will contact the health care practitioner to see if the school orders need to be revised.

## SLIDING SCALE

Do NOT overlap ranges (e.g. enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. Use pre-treatment bG to calculate insulin dose unless other orders.

| ☐Lunch<br>☐Snack<br>☐Breakfast<br>☐Correction Dose | bG<br>Zero -___<br>___-___<br>___-___<br>___-___<br>___-___<br>___-___<br>___-___ | Units Insulin<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |
|---|---|---|

| ☐Other Time | bG | Units Insulin |
|---|---|---|
| _____ | Zero -___ | _____ |
| ☐Snack | ___-___ | _____ |
| ☐Breakfast | ___-___ | _____ |
| ☐Correction Dose | ___-___ | _____ |
| | ___-___ | _____ |
| | ___-___ | _____ |

## OPTIONAL ORDERS

☐ Round insulin dosing to nearest whole unit: 0.51-1.50u rounds to 1.00u.
☐ Round insulin dosing to nearest half unit: 0.26-0.75u rounds to 0.50 u (must have half unit syringe/pen).
☐ Use sliding scale for correction AND at meals ADD: ___ units for lunch; ___ units for snack; ___ units for breakfast (sliding scale must be marked as correction dose only).
☐ Long acting insulin given in school – Insulin Name:_____
Dose:_____ units Time _____ or ☐Lunch

### SNACK ORDERS

☐ Student may carry and self-administer snack
Snack time of day: _____ AM / PM ☐ Pre-gym Snack
Type & amount of snack:

**OTHER ORDERS:**

### HOME MEDICATIONS

| Medication | Dose | Frequency | Time | Route |
|---|---|---|---|---|
| Insulin: | | | | |
| Other: | | | | |

## ADDITIONAL INFORMATION

Is the child using altered or non-FDA approved equipment? ☐ Yes or ☐ No [*Please note that New York State Education laws prohibit nurses from managing non-FDA devices. Please provide pump-failure and/or back up orders on DMAF Part A Form.]*

By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s).

| **Health Care Practitioner Name** LAST FIRST<br>(**Please print and check one:** ☐ MD, ☐ DO, ☐ NP, ☐ PA) | Signature | Date __ __ / __ __ / __ __ __ __ |
|---|---|---|
| Address | Tel. (__ __ __) __ __ __ - __ __ __ __ | Fax. (__ __ __) __ __ __ - __ __ __ __ |
| NYS License # **(Required)** E-mail | **CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.** | |

**DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945.**

## PARENTS/GUARDIANS FILL BELOW

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

1. I consent to the nurse giving my child's prescribed medicine, and the nurse/trained staff checking their blood sugar and treating their low blood sugar based on the directions and skill level determined by my child's health care practitioner. These actions may be performed on school grounds or during school trips.
2. I also consent to any equipment needed for my child's medicine being stored and used at school.
3. I understand that:
   - I must give the school nurse my child's medicine, snacks, equipment, and supplies and must replace such medicine, snacks, equipment and supplies as needed. OSH recommends the use of safety lancets and other safety needle devices and supplies to check my child's blood sugar levels and give insulin.
   - **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 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 OSH to provide diabetes-related 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.
   - OSH and the Department of Education (DOE) are responsible for making sure that my child can safely test his or her blood sugar.
   - This form represents my consent and request for the diabetes 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.

**OSH Parent Hotline for questions about the Diabetes Medication Administration Form (DMAF): 718-310-2496**

### 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 them 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 them 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 Glucagon if prescribed by their health care provider if my child is temporarily unable to carry and take medicine. **This does not include nasal Glucagon as New York State does not endorse training non-licensed personnel to administer nasal Glucagon at this time.**

**NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.**

| **Student** Last Name | First Name | MI | Date of birth __ __ / __ __ / __ __ __ __ |
|---|---|---|---|
| **School ATSDBN/Name** | Borough Select Borough | | District |
| **Print Parent/Guardian's Name** | **SIGN HERE** **Parent/Guardian's Signature for Parts A & B** | | 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** ( __ __ __ ) __ __ __ - __ __ __ __ | |

# DIABETES MEDICATION ADMINISTRATION FORM

Provider Medication Order Form – Office of School Health – School Year **2020-2021**

**DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945.**

## 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

**Notes:**

Attach student photo here

# GENERAL MEDICATION ADMINISTRATION FORM

**THIS FORM SHOULD NOT BE USED FOR SEIZURE, ASTHMA OR ALLERGY MEDICATIONS**

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** __ __ __ __ __ __ __ __ __

| **School (include ATSDBN/name, address and borough)** | **DOE District** | **Grade** | **Class** |
|---|---|---|---|
| | | | |

## HEALTH CARE PRACTITIONERS COMPLETE BELOW

**1. Diagnosis:** _____ ICD-10 Code: ☐ _ _ _ . _ _ _

**Medication:** _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

**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

**Initial below** for Independent (Not allowed for controlled substances)

Practitioner's Initials _____ I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

In School Instructions *(please specify AM / PM)*

Standing daily dose: at __ __ : __ __ AM / PM and __ __ : __ __ AM / PM

**AND/OR**

☐ PRN

_____
*specify signs, symptoms, or situations*

☐ Time interval: __ __ minutes or __ __ hours as needed.

☐ If no improvement, repeat in __ __ minutes or __ __ hours for a maximum of ____ times.

Conditions under which medication should not be given:

---

**2. Diagnosis:** _____ ICD-10 Code: ☐ _ _ _ . _ _ _

**Medication:** _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

**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

**Initial below** for Independent (Not allowed for controlled substances)

Practitioner's Initials _____ I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

In School Instructions

☐ Standing daily dose: at __ __ : __ __ AM / PM and __ __ : __ __ AM / PM

**AND/OR**

☐ PRN

_____
*specify signs, symptoms, or situations*

☐ Time interval: __ __ minutes or __ __ hours as needed.

☐ If no improvement, repeat in __ __ minutes or __ __ hours for a maximum of ____ times.

Conditions under which medication should not be given:

---

**3. Diagnosis:** _____ ICD-10 Code: ☐ _ _ _ . _ _ _

**Medication:** _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

**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

**Initial below** for Independent (Not allowed for controlled substances)

Practitioner's Initials _____ I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

In School Instructions

☐ Standing daily dose: at __ __ : __ __ am / pm and __ __ : __ __ AM / PM

**AND/OR**

☐ PRN

_____
*specify signs, symptoms, or situations*

☐ Time interval: __ __ minutes or __ __ hours as needed.

☐ If no improvement, repeat in __ __ minutes or __ __ hours for a maximum of ____ times.

Conditions under which medication should not be given:

---

**HOME MEDICATIONS (include over-the counter)**

---

**Health Care Practitioner Name** LAST FIRST

**Please print and circle one:** MD DO NP PA

Signature _____ Date __ __ / __ __ / __ __ __ __

Address _____

Tel. ( __ __ __ ) __ __ __ - __ __ __ __ Fax. ( __ __ __ ) __ __ __ - __ __ __ __

NYS License # **(Required)** _____ NPI # __ __ __ __ __ __ __ __ __ __

**INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS**

**FORMS CANNOT BE COMPLETED BY A RESIDENT**



**PARENTS MUST SIGN PAGE 2 ➔**

# GENERAL MEDICATION ADMINISTRATION FORM

**THIS FORM SHOULD NOT BE USED FOR SEIZURE, ASTHMA OR ALLERGY MEDICATIONS**

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.
   - **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 must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions**.**
   - **No student is allowed to carry or give him or herself controlled substances.**
   - The Office of School Health (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), OSH may 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 medication 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:** It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

| **Student** Last Name | First Name | MI | Date of birth __ __ / __ __ / __ __ __ __ |
|---|---|---|---|
| **School ATSDBN/Name** | Borough: Select Borough | | District |
| **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** | **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

FOR PRINT USE ONLY

# GARDEN SCHOOL

Jackson Heights, New York

Christopher Herman, *Head of School*

**Dispensing Medications**

Student Name_____ Date of Birth_____ Gender _____ Grade _____

**PRESCRIPTION MEDICATIONS**

Medication _____ Dosage/Time/ Route _____

Medication _____ Dosage/Time/ Route _____

Medication _____ Dosage/Time/ Route _____

If AM dose is missed at home Nurse may administer

**PERMISSION TO RECEIVE OVER THE COUNTER MEDICATION**
**Health Care Provider and Parent Signature REQUIRED**

| | |
|---|---|
| Acetaminophen 160 mg/5ml liquid (pain, fever) | Dose _____Freq. _____ Route _____ |
| Acetaminophen 325 mg tablets (pain, fever) | Dose _____Freq. _____ Route _____ |
| Ibuprofen 100mg/5ml liquid (pain, fever) | Dose _____Freq. _____ Route _____ |
| Ibuprofen 200mg tablets (pain, fever) | Dose _____Freq. _____ Route _____ |
| Diphenhydramine 12.5 mg/5ml liquid | Dose _____Freq. _____ Route _____ |
| Diphenhydramine 25mg tablets | Dose _____Freq. _____ Route _____ |
| Calcium Carbonate (Tums) 500mg tablets | Dose _____Freq. _____ Route _____ |
| Hydrocortisone 1% cream (itch, localized rash) | Dose _____Freq. _____ Route _____ |
| Bacitracin ointment (cuts, scrapes, burns) | Dose _____Freq. _____ Route _____ |
| Cough drops/throat lozenges (sore throat) | Dose _____Freq. _____ Route _____ |

ATT: Health Care Provider-Please complete dose, frequency, and route. Per package instructions or weight is not accepted. Thank you!

**SIGNATURES ARE REQUIRED IN ORDER FOR SCHOOL NURSE TO DISPENSE MEDICATION OF ANY KIND**

Physician/Practitioner Signature _____ Phone _____

Name/Address _____ Fax _____

(May use stamp below)

Parent/Guardian Signature _____ Date _____

***Parent/Guardian signature authorizes the school nurse to communicate with child's physician regarding prescription and over the counter medications.

**ADDITIONAL COMMENTS** _____

_____

_____