# Letters from the school nurse:
# (Cartas de la enfermera escolar)

Ms. Sandy Klausner
School Nurse

Woodward
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201 West Merrick Road
Freeport, NY 11520
Tel: (516) 379-0900
Fax: (516) 379-0997
www.woodwardchildren.org
Gregory Ingino, Executive Director
Danielle Colucci, Principal

*A note from the School Nurse……*

August 12, 2021

Dear Parent/Guardian:

My name is Sandy Klausner and I am very excited and looking forward to working very closely with you and your child to maintain the best and healthiest environment.

As the school year begins, I would like to remind parent/guardians of some important issues that need to be addressed, that will help your children healthy and in school. Health history, medication orders and care plans **MUST** be done every school year. If it was done for the 2020-2021 school year it is no longer in effect for the 2021-2022 school year. Please contact the school nurse if you have further questions.

According to New York Licensing Laws, as a Registered Professional Nurse (RN), I cannot administer any medication over the counter or prescribed, without written authorization from a parent/guardian AS WELL AS YOUR PHYSICIAN.

As always, any changes in medication and/or allergies with children should be reported as soon as possible. I will be reviewing all immunizations, screenings, and medications of students, and will contact you if updates are needed.

Illnesses and absences should be called into the School Health Office in the morning of the missed school day. Please make me aware if your child is taken to the doctor or diagnosed with any illness.

Please be certain that if your child is sick, they stay home.

I thank you for your time and encourage you to reach out with any and all concerns at (516) 379-0900 ext 210.

Sincerely,

*Sandy Klausner*, RN
School Nurse

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*Una note de la enfermera escuelar……*

11 de agosto del 2020

Estimado Padres/Tutores:

Mi nombre es Sandy Klausner y estoy muy contenta de trabajar con usted y su hijo/a para mantener el mejor y más saludable ambiente.

En el comienzo de este año escolar, me gustaría recordarles a los padres/tutores algunos asuntos importantes que deben abordarse y que ayudarán a sus hijos a estar sanos y en la escuela. El historial médico, los pedidos de medicamentos y los planes de atención DEBEN realizarse cada año escolar. Si se hizo uno para el año escolar 2020-2021, ya no estará vigente para el año escolar 2021-2022. Comuníquese con la enfermera de la escuela si tiene más preguntas.

De acuerdo con las Leyes de Licencias de Nueva York, como Enfermera Profesional Registrada (RN), no puedo administrar ningún medicamento de venta libre ó recetado, sin la autorización por escrito del padre/tutor, ASÍ COMO DE SU MÉDICO.

Como siempre, cualquier cambio en la medicación y / ó alergias en los niños debe notificarse lo antes posible. Revisaré todas las vacunas, exámenes y medicamentos de los estudiantes y me pondré en contacto con usted si se necesitan actualizaciones.

Las enfermedades y ausencias se deben de notificar llamando a la Oficina de Salud Escolar en la mañana del día escolar perdido. Por favor, avíseme si llevan a su hijo al médico ó si le diagnostican alguna enfermedad.

Asegúrese de que si su hijo/a este enfermo, se quede en casa.

Le agradezco su tiempo y le exhorto a comunicarse conmigo si tiene alguna inquietud (516) 379-0900 ext 210.

Atentamente,

*Sandy Klausner,* RN
Enfermera Escolar

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# IMMUNIZATION UPDATE

August 12, 2021

Dear Parent/Guardian,

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

**Children attending summer or year-round programming**

Children who had a religious exemption and who will be attending child care or public, private or parochial school in the summer must now receive the first age-appropriate dose in each immunization series by June 28, 2019 to attend or remain in school or child care. Additionally, by July 14, 2019, parents and guardians of such children must show that they have scheduled appointments for all required follow-up doses.

**Children attending until the end of the school year, returning in the 2021-2022 school year**

Students must meet immunization requirements in order to attend school. Children who have not received all required immunizations must receive the first dose in each immunization series within 14 calendar days after the first day of school or enrollment in child care. Within 30 calendar days of the first day of school, parents or guardians of such children will also need to show that they have scheduled appointments for all follow-up doses.

A list of the new school immunization requirements for the 2021-2022 school year is summarized below.

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

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

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

- Tdap booster (tetanus, diphtheria and pertussis) by grade 6
- MenACWY (meningococcal disease) by grade 7

Please review your child's immunization history with their health care provider. Their provider can tell you whether additional doses of one or more vaccines are required for your child to attend or remain in child care or school.

Please read contents of immunization requirements for your child to be kept for your records. Kindly, sign and date the bottom part of this letter and return to school.

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

---

***(Cut, sign and return to Woodward)***

Parent/Guardian Signature:_____Date:_____

Student Name:_____

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# ACTUALIZACIÓN DE VACUNAS

12 de agosto del 2021

Estimado Padre/Tutor:

A partir del 13 de junio de 2019, las escuelas públicas, privadas y parroquiales y los programas de cuidado infantil en Nueva York ya no pueden aceptar solicitudes de exenciones religiosas de los requisitos de inmunización escolar. Esta ley se aplica a los estudiantes de prejardín de infantes a 12º grado y a todos los entornos de cuidado infantil. Las escuelas y los programas de cuidado infantil continuarán aceptando exenciones médicas.

**Niños que asisten a programas de verano ó durante todo el año.**
Los niños que tenían una exención religiosa y que asistirán a guarderías o escuelas públicas, privadas o parroquiales en el verano ahora deben recibir la primera dosis apropiada para su edad en cada serie de vacunas antes del 28 de junio de 2019 para asistir o permanecer en la escuela o guardería. Además, antes del 14 de julio de 2019, los padres y tutores de dichos niños deben demostrar que tienen citas programadas para todas las dosis de seguimiento requeridas.

**Niños que asisten hasta el final del año escolar y regresan en el año escolar 2021-2022.**
Los estudiantes deben cumplir con los requisitos de inmunización para poder asistir a la escuela. Los niños que no han recibido todas las vacunas requeridas deben recibir la primera dosis en cada serie de vacunas dentro de los 14 días calendario posterior al primer día de escuela o inscripción en el cuidado infantil. Dentro de los 30 días calendario del primer día de clases, los padres o tutores de dichos niños también deberán demostrar que tienen citas programadas para todas las dosis de seguimiento.

A continuación se resume una lista de los nuevos requisitos de vacunación escolar para el año escolar 2021-2022.

**Todos los estudiantes en cuidado infantil hasta el grado 12** deben cumplir con los requisitos para las siguientes vacunas:
- DTaP (difteria, tétanos y tos ferina acelular o tos ferina)
- Poliovirus
- MMR (sarampión, paperas y rubéola)
- Varicela (varicela)
- Hepatitis B

**Los niños en los grados 6 a 12** también deben cumplir con los requisitos para estas vacunas:
- Refuerzo de Tdap (tétanos, difteria y tos ferina) para el grado 6
- MenACWY (enfermedad meningocócica) por grado 7

Revise el historial de vacunas de su hijo con su proveedor de atención médica. Su proveedor puede decirle si se requieren dosis adicionales de una o más vacunas para que su hijo asista o permanezca en la guardería o en la escuela.

Lea el contenido de los requisitos de vacunación para que su hijo se mantenga en sus registros. Por favor, firme y feche la parte inferior de esta carta y devuélvala a la escuela.

Si tiene preguntas sobre estos requisitos, comuníquese con el centro de cuidado infantil o la oficina administrativa de la escuela.

---

***(Recorte, firme y regrese a Woodward)***

Firma del Padre/Tutor:_____Fecha:_____

Nombre del Estudiante:_____

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August 12, 2021

Dear Parent/Guardian:

I hope you have enjoyed the summer! It is that time again to start working on the updated forms for the new school year. If you received this letter, then your child needs or will need updated information. Forms where mailed out over the summer, please update the information that pertains to you.

**Updated information required for your child:**

___Required NYS School Health Examination Form
___General Medication Administration Form
Parent/Guardian MUST sign page 2
___Over-the-Counter-Medication Administration-Consent form
MUST be signed/dated by Physician
MUST be signed/dated by Parent/Guardian
___Allergies/Anaphylaxis Medication Administration Form
MUST be signed/dated by Parent/Guardian, page 2
___Asthma Medication Administration Form
MUST be signed/dated by Parent/Guardian, page 2
___Asthma Action Plan
MUST be signed/dated by Parent/Guardian, to self-carry if ordered by Physician
___Administration of Medication in School and for School Activities Form
MUST be signed/dated by Physician
MUST be signed/dated by Parent/Guardian
___Diabetic Medication Administration Form (Part A)

Thank you for your cooperation.

Sincerely,

*Sandy Klausner, RN*
School Nurse

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12 de agosto del 2021

Estimado Padre/Tutor:

Hola y espero hallan disfrutado del verano! Es ese tiempo otra vez para empezar a trabajar en los formularios de salud y actualizarlos para el nuevo año escolar. Si usted recibe está carta entonces su hijo/a necesita ó necesitará información actualizada. Las formulas nuevas fueron enviados por correo durante el verano, por favor actualice la información que pertenece a hijo/a.

**Los formularios que necesitan ser actualizados para su hijo/a son los siguientes: Updated information required for your child:**

___Required NYS School Health Examination Form (Formulario de examen de salud escolar obligatorio del Estado de Nueva York)
___General Medication Administration Form, Parent/Guardian MUST sign page 2 (Formulario General de Administración de Medicamentos. El padre / tutor DEBE firmar la página 2)
___Over-the-Counter-Medication Administration-Consent form (Formulario de consentimiento para la administración de medicamentos sin receta medica.
DEBE estar firmado / fechado por el médico
DEBE estar firmado / fechado por el padre / tutor)
___Allergies/Anaphylaxis Medication Administration Form, MUST be signed/dated by Parent/Guardian, page 2 (Formulario de administración de medicamentos para alergias / Anafilaxia, DEBE estar firmado / fechado por el padre / tutor, página 2)
___Asthma Medication Administration Form, be signed/dated by Parent/Guardian, page 2 (Formulario de administración de medicamentos para el asma, DEBE estar firmado / fechado por el padre / tutor, página 2)
___Asthma Action Plan, MUST be signed/dated by Parent/Guardian, to self-carry if ordered by Physician (Plan de acción contra el asma DEBE estar firmado / fechado por el padre / tutor, para llevarlo por sí mismo si lo ordena el médico)
___Administration of Medication in School and for School Activities Form, MUST be signed/dated by Physician, MUST be signed/dated by Parent/Guardian (Formulario de administración de medicamentos en la escuela y para actividades escolares DEBE estar firmado / fechado por el médico DEBE estar firmado / fechado por el padre / tutor)
___Diabetic Medication Administration Form (Part A) (Formulario de administración de medicamentos para diabéticos (Parte A))

Atentamente,

*Sandy Klausner, RN*
Enfermera Escolar

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# OVER-THE-COUNTER-MEDICATION-CONSENT FORM

**Student Name:**_____ **DOB:**_____

I give permission for the above named student to be given as needed dosage of the medication below in accordance with medication label.

**NSAID (Motrin, Advil)** or the generic equilvalent for aches/pains/fever.

Yes _____ No _____

**(Tylenol)** or the generic equivalent for fever/aches/pains.

Yes _____ No _____

(**Benadryl)** or the generic equivalent for allergic.

Yes _____ No _____

**(Tums/Pepto Bismol)** or generic equivalent for upset stomach/diarrea.

Yes _____ No _____

**Please check off the following topical and or antiseptics allowed to be used for minor cuts, scrapes, burns, itch, and bug bites:**

_____ Triple Antibiotic Cream/Bacitracin/Neosporin/First Aid Burn Cream

_____ Hydrocortisone 1% Cream/Benadrly Cream

_____ Saline Wound Flush Hydrogen Peroxide

**Parent/Guardian Signature:** _____**Date:**_____

**Physician Signature/Stamp**: _____**Date**:_____

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# MEDICAMENTOS SIN RECETA MÉDICA (OVER-THE-COUNTER)

**Nombre del Estudiante**:_____**Fecha de Nacimiento**:_____

Doy permiso para que el estudiante mencionado arriba, reciba la dosis necesaria, de acuerdo con la etiqueta del medicamento.

**NSAID (Motrin, Advil)** ó el equivalente genérico para los dolores y fiebre.

Si _____ No _____

**(Tylenol)** ó el equivalente genérico para los dolores y fiebre.

Si _____ No _____

(**Benadryl)** ó el equivalente genérico para el reacciones alérgicas.

Si _____ No _____

**(Tums/Pepto Bismol)** ó el equivalente genérico de estomago descompuesto/diarrea.

Si _____ No _____

**Por favor complete la siguiente información de antisépticos permitidos a utilizarse para cortes, picaduras, raspones, sarpullido, quemaduras menores, y picaduras de insectos:**

_____ Crema antibiótica Triple/Bacitracina/Neosporin /Primeros Auxilios Crema Para Quemaduras

_____ Hidrocortisona al 1% Crema / Benadrly Crema

_____Peróxido de hidrógeno de solución salina para las heridas

**Firma del Padre/Tutor**:_____**Fecha**:_____

**Firma del Médico/Estampilla**:_____**Fecha**:_____

Woodward Children's Center - 201 W. Merrick Road - Freeport, NY 11520
Tel. 516-379-0900 Fax. 516-379-0997

# REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

**TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**
**IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

## STUDENT INFORMATION

| Name | Sex: ☐ M ☐ F | DOB: |
|---|---|---|
| School: | Grade: | Exam Date: |

## HEALTH HISTORY

| | |
|---|---|
| **Allergies** ☐ No<br>☐ Yes, indicate type | Type:<br>☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached |
| **Asthma** ☐ No<br>☐ Yes, indicate type | ☐ Intermittent ☐ Persistent ☐ Other :<br>☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached |
| **Seizures** ☐ No<br>☐ Yes, indicate type | Type: Date of last seizure:<br>☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached |
| **Diabetes** ☐ No<br>☐ Yes, indicate type | Type: ☐ 1 ☐ 2<br>☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached |

**Risk Factors for Diabetes or Pre-Diabetes:** *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

**BMI**_____kg/m2

**Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

**Hyperlipidemia:** ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

## PHYSICAL EXAMINATION/ASSESSMENT

**Height:** **Weight:** **BP:** **Pulse:** **Respirations:**

| Laboratory Testing | Positive | Negative | Date | List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ) |
|---|---|---|---|---|
| TB- PRN | ☐ | ☐ | | |
| Sickle Cell Screen-PRN | ☐ | ☐ | | |
| **Lead Level Required Grades Pre- K & K** | | | **Date** | |
| ☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL | | | | |

☐ **System Review and Abnormal Findings Listed Below**

| | | | | |
|---|---|---|---|---|
| ☐ HEENT | ☐ Lymph nodes | ☐ Abdomen | ☐ Extremities | ☐ Speech |
| ☐ Dental | ☐ Cardiovascular | ☐ Back/Spine | ☐ Skin | ☐ Social Emotional |
| ☐ Neck | ☐ Lungs | ☐ Genitourinary | ☐ Neurological | ☐ Musculoskeletal |

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

| Name: | DOB: |
|---|---|

**SCREENINGS**

| **Vision** (w/correction if prescribed) | **Right** | **Left** | **Referral** | **Not Done** |
|---|---|---|---|---|
| Distance Acuity | 20/ | 20/ | ☐ Yes ☐ No | ☐ |
| Near Vision Acuity | 20/ | 20/ | | ☐ |
| Color Perception Screening ☐ Pass ☐ Fail | | | | ☐ |
| Notes | | | | |

| **Hearing** Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz. | | | **Not Done** |
|---|---|---|---|
| Pure Tone Screening | **Right** ☐ Pass ☐ Fail | **Left** ☐ Pass ☐ Fail | **Referral** ☐ Yes ☐ No ☐ |
| Notes | | | |

| **Scoliosis** Screen Boys in grade 9, and Girls in grades 5 & 7 | **Negative** | **Positive** | **Referral** | **Not Done** |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ Yes ☐ No | ☐ |

**RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK**

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.

☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

☐ **Other Restrictions:**

**Developmental Stage for Athletic Placement Process <u>ONLY</u> required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

**Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

**MEDICATIONS**

☐ **Order Form for Medication(s) Needed at School Attached**

**IMMUNIZATIONS**

☐ Record Attached ☐ Reported in NYSIIS

**HEALTH CARE PROVIDER**

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

**Please Return This Form To Your Child's School When Completed.**

Attach student photo here

# GENERAL MEDICATION ADMINISTRATION FORM

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

Provider Medication Order Form | Office of School Health | School Year **2021–2022**

**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 ATS DBN/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 during school, field trips, and 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:

---

**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 during school, field trips, and 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 during school , field trips, and 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)** ☐ **None**

| **Health Care Practitioner Name** LAST (**Please print and circle one:** MD, DO, NP, PA) | FIRST | 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**

Rev 3/21

**PARENTS MUST SIGN PAGE 2 ➔**

# GENERAL MEDICATION ADMINISTRATION FORM

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

Provider Medication Order Form | Office of School Health | School Year **2021–2022**

**Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.**

**PARENTS/GUARDIANS READ, COMPLETE, AND SIGN. 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 | | 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** ☐ Clarified ☐ Modified

*Confidential Information should not be sent by email

FOR PRINT USE ONLY

Woodward Children's Center
201 West Merrick
Freeport, NY 11520

Tel: (516) 379-0900
Fax: (516) 379-0997
www.woodwardchildren.org

**PARENT AND PHYSICIAN(S) AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES MEDICATION ORDERS MUST BE RENEWED EVERY YEAR**

**A. To be completed by the Parent/Guardian:**

I request that my child _____ DOB:_____
Receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.* I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including trips.

Signature Parent/Guardian:_____

Home:_____ Cell: _____ Work:_____

**B. To be completed by Physician:**

I request that my patient, as listed below, receive the following medication during the school day:

Name of Student:_____DOB:_____

Diagnosis:_____

| Medication | Dosage | Frequency/Time to be taken | Route of Administration |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Duration of treatment _____

Possible side effects/adverse reactions (if any):_____

_____

Physician's Signature:_____Date:_____

Address:_____

Phone:_____ Fax:_____

*Medication must be in original pharmacy labeled container with student name, specific directions, and name of medication. Medication and refills must be brought to school by parent/guardian.

Plan reviewed with parent/guardian:_____
*School Nurse Signature/Date*

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Freeport, NY 11520

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Fax: (516) 379-0997
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# TRANSPORTATION PLAN

Transportation Plan:

- ☐ Medication available on the bus
- ☐ Medication NOT available on the bus
- ☐ Does not ride bus
- ☐

Special Instructions:_____

Healthcare Provider Signature:_____ Date:_____Phone:_____

Written by:_____ Date:_____

- ☐ Copy provided to Parent
- ☐ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff:_____

Woodward Children's Center
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Freeport, NY 11520

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**AUTORIZACIÓN DE PADRES Y MÉDICOS PARA LA ADMINISTRACIÓN DE MEDICAMENTOS EN LA ESCUELA Y LAS ACTIVIDADES ESCOLARES LOS PEDIDOS DE MEDICACIÓN DEBEN SER RENOVADOS CADA AÑO**

**A. Para ser completado por el Padre/Tutor:**

Solicito que mi hijo/a _____ Fecha de nacimiento: _____
Reciba el medicamento según lo prescrito a continuación por nuestro médico. El medicamento debe ser provisto por mí en el envase original debidamente etiquetado de la farmacia. * Entiendo que la enfermera de la escuela u otra persona designada en caso de ausencia de la enfermera de la escuela, administrará el medicamento, incluidos los viajes.

Firma del Padre/Tutor:_____

Cellular:_____ Tel de la casa: _____ Trabajo:_____

**B. Para ser completado por el médico:**

Solicito que mi paciente, como se detalla a continuación, reciba el siguiente medicamento durante el día escolar:

Nombre del Estuidante:_____Fecha de Nacimiento:_____

Diagnóstico:_____

| Medicamento | Dosis | Frecuencia / Tiempo a tomar | Como administrar |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Duración del tratamiento _____

Posibles efectos secundarios / reacciones adversas (si las hay):_____

_____

Firma del médico:_____Fecha:_____

Residencia:_____

Phone:_____ Fax:_____

* El medicamento debe estar en el envase original etiquetado de la farmacia con el nombre del estudiante, las instrucciones específicas y el nombre del medicamento. Los medicamentos y las recargas deben ser llevados a la escuela por el padre / tutor.

Plan revisado con el padre / tutor:_____
*Firma de la enfermera de la escuela/Fecha*

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# PLAN DE TRANSPORTACION

Plan de transportación:

- ☐ Medicamentos disponibles en el autobús.
- ☐ Medicación no sera disponible en el bus.
- ☐ No coje el autobús.

Instrucciones especiales:_____

Firma del médico:_____ Fecha:_____Teléfono:_____

Escrito por:_____Fecha:_____

- ☐ Copia a el padre/tutor
- ☐ Copia para el médico

Firma del padre / tutor para compartir este plan con el proveedor y el personal de la escuela:_____

Attach student photo here

# ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year **2021-2022**

**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 | Y ☐ | N ☐ | U ☐ | ☐ | ____ times last : __ __ /__ __ /__ __ |
| History of asthma-related hospitalizations within past 12 months | Y ☐ | N ☐ | U ☐ | ☐ | ____ times last : __ __ /__ __ /__ __ |
| History of 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 during school, field trips , and 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/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 q 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)* ☐ None

☐ 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 4/21**
**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 **2021-2022**

**Please return to school nurse. Forms submitted after June 1, 2020 may delay processing for new school year.**

**PARENTS/GUARDIANS READ, COMLETE, AND SIGN. 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: ☐ Clarified ☐ 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 |

| | | | **Does this student have the ability to:** | | |
|---|---|---|---|---|---|
| **History of asthma?** | ☐ Yes ***(If yes, student has an increased risk for a severe reaction)*** | ☐ No | | | |
| **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

# Asthma Action Plan

Date Completed

| Name | Date of Birth | Grade/Teacher |
|---|---|---|
| Health Care Provider | Health Care Provider's Office Phone | Medical Record Number |
| Parent/Guardian | Phone | Alternate Phone |
| Parent/Guardian/Alternate Emergency Contact | Phone | Alternate Phone |

**DIAGNOSIS OF ASTHMA SEVERITY**

☐ Intermittent ☐ Persistent [ ◯ Mild ◯ Moderate ◯ Severe ]

**ASTHMA TRIGGERS** (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other _____

## GREEN ZONE: GO!

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

**You have ALL of these:**
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

☐ No daily controller medicines required

☐ Daily controller medicine(s):_____

☐ _____

**Take _____ puff(s) or _____ tablet(s) _____ daily.**

☐ For asthma with exercise, ADD: _____,

**_____ puffs with spacer _____ minutes before exercise**

**ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.**

## YELLOW ZONE: CAUTION!

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

**You have ANY of these:**
- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ _____ inhaler _____ mcg

**Take _____ puffs every _____ hours, *if needed*. Always use a spacer, some children may need a mask.**

☐ _____ nebulizer _____ mg /_____ ml

**Take a _____ nebulizer treatment every _____ hours, *if needed*.**

☐ Other _____

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider

**IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.**

## RED ZONE: EMERGENCY!

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

**You have ANY of these:**
- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

☐ _____ inhaler _____ mcg

**Take _____ puffs every _____ hours, *if needed*. Always use a spacer, some children may need a mask.**

☐ _____ nebulizer _____ mg /_____ ml

**Take a _____ nebulizer treatment every _____ hours, *if needed*.**

☐ Other _____

**CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!**

## REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

**Health Care Provider Permission:** I request this plan to be followed as written. This plan is valid for the school year _____ – _____ .

Signature _____ Date _____

**Parent/Guardian Permission:** I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature _____ Date _____

## OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

**Health Care Provider Independent Carry and Use Permission:** I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

**Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above):** I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____



COPY FOR PATIENT