

Attach student photo here

REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment 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: Sex: OSIS Number: Grade: Class: DOE District: School (include ATSDBN/name, address, and borough):

HEALTHCARE PRACTITIONERS COMPLETE BELOW

ONE ORDER PER FORM (make copies of this form for additional orders). Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization.

- Checkboxes for various medical treatments: Blood Pressure Monitoring, Chest Clapping/Percussion, Clean Intermittent Catheterization, Central Line, Dressing Change, Feeding, Nasogastric, G-Tube, J-Tube, Bolus, Pump, Gravity, Spec./Non-Standard*, Feeding Tube replacement, Oral / Pharyngeal Suctioning, Ostomy Care, Oxygen Administration, Postural Drainage, Pulse Oximetry monitoring, Trach Care, Trach Suctioning, Trach Replacement, Vagus Nerve Stimulator, Other.

Student will also require treatment: during transport, on school-sponsored trips, during afterschool programs

Student Skill Level (Select the most appropriate option):

- Checkboxes for student skill levels: Nurse-Dependent Student, Supervised Student, Independent Student.

I attest student demonstrated the ability to self-administer the prescribed treatment effectively during school, field trips, and school-sponsored events

Practitioner's initials

Diagnosis: Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS) Diagnosis is self-limited: Yes No

1. Treatment required in school:

Feeding: Formula Name: Concentration: Route: Amount/Rate: Duration: Frequency/specific time(s) of administration:

Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.

Flush with mL Before feeding After feeding Oxygen Administration: Amount (L): Route: Frequency/specific time(s) of administration: prn O2 Sat < % Specify signs & symptoms:

Other Treatment: Treatment Name: Route: Frequency/specific time(s) of administration: Specify signs & symptoms:

Additional Instructions or Treatment:

2. Conditions under which treatment should not be provided:

3. Possible side effects/adverse reactions to treatment:

4. Emergency Treatment: Provide specific instructions for nurse (if one is assigned and present) in case of emergency, including adversereactions, including dislodgement or blockage of tracheostomy, or feeding tube:

5. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:

6. Date(s) when treatment should be: Initiated: Terminated:

Health Care Practitioner

Last Name: First Name: MD DO NP PA Address: Tel. No: Fax No: Cell phone: Email: NYS License No (Required): NPI No Date: Practitioner's Signature:

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PARENT/GUARDIAN READ, COMPLETE, AND SIGN: BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medical supplies, equipment and prescribed treatments being stored and given at school based on directions from my child's health care practitioner.
2. I understand that:
 - I must give the school nurse my child's medical supplies, equipment and treatments.
 - **All supplies I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired supplies for my child's use during school days.**
 - Supplies, equipment and treatments should be labeled with my child's name and date of birth.
 - I must **immediately** tell the school nurse about any change in my child's treatments or the health care practitioner's instructions.
 - 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 form, I authorize 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 treatment instructions/orders on this form expire at the end of my child's school year, which may include the summer session, or when I give the school nurse a new form (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 medical 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-TREATMENT (INDEPENDENT STUDENTS ONLY)

- I certify/confirm that my child has been fully trained and can perform treatments on his or her own. I consent to my child carrying, storing and giving him or herself, the treatments prescribed on this form in school. I am responsible for giving my child these supplies and equipment labeled as described above. I am also responsible for monitoring my child's treatments, and for all results of my child's self-treatment in school. The school nurse will confirm my child's ability to perform treatments on his/her own. I also agree to give the school clearly labeled "back up" equipment or supplies in the event that my child is unable to self-treat.

Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.

Student Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

School ATSDBN/Name: _____

Borough: _____ District: _____

Parent/Guardian's Email: _____ Parent/Guardian's Address: _____

Telephone Numbers: Daytime: _____ Home: _____ Cell Phone*: _____

Parent/Guardian's Name: _____ Parent/Guardian's Signature: _____

Date Signed: _____

Alternate Emergency Contact:

Name: _____ Relationship to Student: _____ Contact Number: _____

FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

OSIS Number: _____

Received by: Name: _____ Date: _____ Reviewed by: _____ 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 e-mail.

FOR PRINT USE ONLY