

ASTHMA

MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication to Students for School Year 2016-2017

ATTACH STUDENT PHOTO HERE	Student Last Name	First Name	Middle	Date of birth ____/____/____ M M D D Y Y Y Y	<input type="checkbox"/> Male <input type="checkbox"/> Female
	School (include name, number, address and borough)			DOE District	Grade

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY STUDENT'S HEALTH CARE PRACTITIONER

Diagnosis	Select Asthma Severity and Control				
<input type="checkbox"/> Asthma	Severity:	<input type="checkbox"/> Intermittent	<input type="checkbox"/> Mild Persistent	<input type="checkbox"/> Moderate Persistent	<input type="checkbox"/> Severe Persistent
Other:	Control:	<input type="checkbox"/> Well-controlled		<input type="checkbox"/> Poorly Controlled (includes Not Controlled category)	

Student Asthma Risk Assessment Questionnaire (Y = Yes; N = No; U = Unknown)

History of near-death asthma requiring mechanical ventilation	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	History of asthma-related:
History of life-threatening asthma (e.g., with loss of consciousness or with hypoxic seizure)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	PICU admissions (ever)
Received oral steroids within past 12 months: ____ times	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	ER visits within past 12 months: ____ times
Date last oral steroids received: ____/____/____				Hospitalizations within past 12 months: ____ times
History of food allergy, eczema, specify _____	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> U	

Select In School ASTHMA Medications	In School Instructions
1. Quick Relief Medications Choose ONLY one: <input type="checkbox"/> Albuterol [<i>Ventolin® can be provided by school for shared usage (plus individual spacer): see back</i>]. <input type="checkbox"/> MDI with spacer <input type="checkbox"/> DPI <input type="checkbox"/> Other Medication Order: Name: _____ Dose: _____ Route: _____ Instructions: Time interval: q ____ hours	<input type="checkbox"/> Standard Order: Give 2 puffs q 4 hours PRN for coughing, wheezing, tightness in chest, difficulty breathing or shortness of breath ("Asthma Flare Symptoms"). Monitor for 20 minutes or until symptom-free. If not symptom-free after 20 minutes may repeat ONCE <p style="text-align: center;">OR</p> If in Respiratory distress* : call 911 and give 6 puffs ; then may repeat 6 puffs q 20 minutes until EMS arrives. <input type="checkbox"/> Pre-exercise: give 2 puffs 15 -20 minutes before exercise. <input type="checkbox"/> URI symptoms or recent asthma flare (within 5 days): give 2 puffs @ noon for 5 days.

2. Controller Medications for In-School Administration (<i>Recommended for Persistent Asthma, per NAEPP Guidelines</i>) SPECIFY Name(s) of medication <input type="checkbox"/> Inhaled corticosteroid (ICS): _____ Strength _____ <input type="checkbox"/> MDI with spacer <input type="checkbox"/> DPI <input type="checkbox"/> Other: _____ Strength _____ Dose: _____ Route: _____ Time interval: q _____	<input type="checkbox"/> Standing daily dose: ____ puffs <i>once a day</i> at ____ AM OR ____ PM OR ____ puffs <i>twice a day</i> at ____ AM and ____ PM Special Instructions: _____
---	---

Select the most appropriate option for this student:

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's initials

**** PARENT MUST INITIAL REVERSE SIDE**

HOME Medications (include over-the counter)	For Office of School Health (OSH) Only
	Revisions per OSH after consultation with prescribing practitioner. <input type="checkbox"/> IEP
	*Respiratory Distress: includes breathlessness at rest, tachypnea, cyanosis, pallor, hunching forward, nasal flaring, accessory respiratory muscle use, abdominal breathing, shallow rapid breathing, talking in words, wheezing throughout expiration and inspiration or decreased or absent breath sounds, agitation, drowsiness, confusion or exceptionally quiet appearance.

Health Care Practitioner (Please Print)	LAST NAME	FIRST NAME	Signature	Date ____/____/____
Address	Tel. (____)____-____		Fax. (____)____-____	
NYS License # (Required) _____	Medicaid# _____	NPI # _____		

CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

ASTHMA
MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH
 Authorization for Administration of Medication to Students for School Year 2016–2017

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

Student Last Name	First Name	MI	Date of birth ___/___/_____	School
--------------------------	------------	----	-----------------------------	--------

PARENT/GUARDIAN'S CONSENT

I hereby consent to the storage and administration of medication, as well as the storage and use of necessary equipment to administer medication, in accordance with the instructions of my child's health care practitioner. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-stock inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that all provided medication must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the school nurse of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this MAF is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction program session; or such time that I deliver to the school nurse new instructions issued by my child's health care practitioner (whichever is earlier). By submitting this MAF, I am requesting that my child be provided specific health services by DOE and the New York City Department of Health and Mental Hygiene (DOHMH) through the Office of School Health (OSH). I understand that these services may include a clinical assessment and a physical examination by an OSH health care practitioner. Full and complete instructions regarding the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form.

I understand that after the MAF expiration date, an OSH health care practitioner may examine my child to evaluate his/her asthma symptoms and my child's response to the prescribed medication, and may issue a new MAF. If the OSH health care practitioner determines that no changes to the orders in the MAF are necessary, the OSH health care practitioner may issue a new MAF with the same orders to expire in one year unless my child's health care practitioner provides a new MAF. If the OSH health care practitioner determines, based on an examination of my child and pertinent medical history, that the orders in the MAF should be changed, the OSH health care practitioner may issue a new MAF with different orders to expire in one year unless my child's health care practitioner provides a new MAF. I, along with my child's health care practitioner of record, will be notified of the issuance of new MAF and of any change in the MAF orders. I further understand that I will have until 30 days before the expiration date of this MAF to submit a new MAF, or to object to this examination in writing, to the school nurse. If I do not submit a new MAF to the school nurse, or notify the school nurse in writing that I object to my child being examined by an OSH health care practitioner, by this deadline, my child may be examined and a new MAF may be issued.

I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request and consent for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I understand that OSH and DOE and their employees and agents, may contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care practitioner and/or pharmacist that has provided medical or health services to my child.

****SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications):**

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further consent to my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, and for any and all consequences of my child's use of such medication in school. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

_____ I consent to the school nurse storing and/or administering to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ **I hereby certify that I have consulted with my child's health care practitioner and that I consent to the Office of School Health administering stock asthma medication in the event that my child's asthma prescription medication is unavailable.**

You must send your child's **Personal Metered Dose Inhaler (MDI)** with your child on a **school trip day** in order that he/she has it available. The stock asthma medication is **only** for use while your child is in the school building.

Parent/Guardian's Signature		Print Parent/Guardian's Name	
Date Signed ___/___/_____		Parent/Guardian's Address	
Telephone Numbers: Daytime (____) _____ - _____ Home (____) _____ - _____ Cell Phone* (____) _____ - _____			
Parent/Guardian e-mail address*			
Alternate Emergency Contact's Name		Contact Telephone Number (____) _____ - _____	
DO NOT WRITE BELOW – FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY			
Received by: Name		Reviewed by: Name	
Date ___/___/_____		Date ___/___/_____	
Self-Administers/Self-Carries: <input type="checkbox"/> Yes <input type="checkbox"/> No		Services provided by: <input type="checkbox"/> Nurse <input type="checkbox"/> OSH Public Health Advisor <input type="checkbox"/> School Based Health Center	
Signature and Title (RN OR MD/DO/NP):			