



# ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2023–2024

Please return to School Nurse/School Based Health Center. Forms submitted after June 1<sup>st</sup> may delay processing for new school year.

Student Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Sex:  Male  Female OSIS Number: \_\_\_\_\_ Weight: \_\_\_\_\_  
School (include name, number, address, and borough): \_\_\_\_\_  
DOE District: \_\_\_\_\_ Grade: \_\_\_\_\_ Class: \_\_\_\_\_

## HEALTH CARE PRACTITIONERS COMPLETE BELOW

### Specify Allergies:

History of asthma?  Yes (If yes, student has an increased risk for a severe reaction; complete the Asthma MAF for this student)  No

History of anaphylaxis?  Yes Date: \_\_\_\_\_  No

If yes, system affected  Respiratory  Skin  GI  Cardiovascular  Neurologic

Treatment: \_\_\_\_\_ Date: \_\_\_\_\_

Does this student have the ability to: Self-Manage (See 'Student Skill Level' below)  Yes  No

Recognize signs of allergic reactions  Yes  No

Recognize and avoid allergens independently  Yes  No

## Select In-School Medications

### SEVERE REACTION

#### A. Immediately administer epinephrine ordered below, then call 911.

0.1 mg  0.15 mg  0.3 mg

Give intramuscularly in the anterolateral thigh for any of the following signs/symptoms (retractable devices preferred) :

- Shortness of breath, wheezing, or coughing
- Fainting or dizziness
- Lip or tongue swelling that bothers breathing
- Pale or bluish skin color
- Tight or hoarse throat
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Weak pulse
- Trouble breathing or swallowing
- Feeling of doom, confusion, altered consciousness or agitation
- Many hives or redness over body

Other: \_\_\_\_\_

If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): \_\_\_\_\_

#### Even if child has MILD signs/symptoms after a sting or eating these foods, give epinephrine and call 911.

B. If no improvement, or if signs/symptoms recur, repeat in \_\_\_\_\_ minutes for maximum of \_\_\_\_\_ times (not to exceed a total of 3 doses)

If this box is checked, give antihistamine after epinephrine administration (order antihistamine below)

### Student Skill Level (select the most appropriate option):

Nurse-Dependent Student: 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 during school, field trips, and school sponsored events - Practitioner's Initials: \_\_\_\_\_

### MILD REACTION (parent must supply medicine for use in medical room)

For any of the following signs and symptoms \_\_\_\_\_, give:

• Benadryl \_\_\_\_\_ mg po Q6 hours prn

• Name: \_\_\_\_\_ Preparation/Concentration: \_\_\_\_\_ Dose: \_\_\_\_\_ PO  Q4 hours  Q6 hours  Q12 hours prn

### 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 during school, field trips, and school sponsored events - Practitioner's Initials: \_\_\_\_\_

### OTHER MEDICATION

• Give Name: \_\_\_\_\_ Preparation/Concentration: \_\_\_\_\_ Dose: \_\_\_\_\_ PO Q \_\_\_\_\_ hours prn

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 during school, field trips, and school sponsored events - Practitioner's Initials: \_\_\_\_\_

Home Medications (include over the counter)  None

### Health Care Practitioner

Last Name (Print): \_\_\_\_\_ First Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

NYS License # (Required): \_\_\_\_\_ NPI #: \_\_\_\_\_ Please check one:  MD  DO  NP  PA Date: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Tel: \_\_\_\_\_ FAX: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

# ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM Provider

Medication Order Form | Office of School Health | School Year 2023–2024

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## PARENTS/GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
- I understand that:
  - I must give the school nurse/school based health center (SBHC) provider 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/SBHC provider 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/SBHC provider a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse/SBHC provider a new MAF written by my child's health care practitioner.
  - 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 Section 504 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/SBHC provider 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 (ATS DBN/Name): \_\_\_\_\_ Borough: \_\_\_\_\_ District: \_\_\_\_\_

Parent/Guardian Name (Print): \_\_\_\_\_ Parent/Guardian's Email: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_

Parent/Guardian Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Other Emergency Contact Name/Relationship: \_\_\_\_\_

Other Emergency Contact Phone: \_\_\_\_\_

### For Office of School Health (OSH) Use Only

OSIS Number: \_\_\_\_\_ Received by - Name: \_\_\_\_\_ Date: \_\_\_\_\_

504  IEP  Other \_\_\_\_\_ Reviewed by - Name: \_\_\_\_\_ Date: \_\_\_\_\_

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 per Office of School Health after consultation with prescribing practitioner:  Clarified  Modified