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** __ __ / __ __/ __ __ __ __ MM DD YYYY | ☐ Male ☐ Female |
|---|---|---|---|---|

**OSIS Number** __ __ __ __ __ __ __ __ __

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

## HEALTHCARE PRACTITIONERS COMPLETE BELOW

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

- ☐ Blood Pressure Monitoring
- ☐ Chest Clapping/Percussion
- ☐ Clean Intermittent Catheterization: Cath Size ___Fr.
- ☐ Central Line
- ☐ Dressing Change
- ☐ Feeding: Cath Size ___Fr.
  - ☐ Nasogastric ☐ G-Tube ☐ J-Tube
  - ☐ Bolus ☐ Pump ☐ Gravity ☐ Spec./Non-Standard*
- ☐ Feeding Tube replacement if dislodged - specify in #5
- ☐ Oral / Pharyngeal Suctioning: Cath Size ____Fr
- ☐ Ostomy Care
- ☐ Oxygen Administration - specify in #2
- ☐ Postural Drainage
- ☐ Pulse Oximetry monitoring
- ☐ Trach Care : Trach. Size_____
- ☐ Trach Replacement - specify in #5
- ☐ Trach Suctioning : Cath Size __Fr
- ☐ 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)*:

- □ Nurse-Dependent Student: nurse must administer treatment
- □ Supervised Student: student self-treats under adult supervision
- □ Independent Student: student is self-carry/self-treat *(initial below)*

☐ **Practitioner's initials**

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

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

2. **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**: _____ _____ □ _____ □ prn □ O2 Sat < _____% □ _____
  Amount (L) | Route | Frequency/specific time(s) of administration | Specify signs & symptoms
- □ **Other Treatment**: _____ _____ □_____ □ prn _____
  Treatment Name | Route | Frequency/specific time(s) of administration | Specify signs & symptoms
- □ **Additional Instructions or Treatment:**

3. Conditions under which treatment should not be provided:

4. Possible side effects/adverse reactions to treatment:

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

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

7. Date(s) when treatment should be: Initiated __ __ / __ __ / __ __ __ __ Terminated __ __ / __ __ / __ __ __ __

| **Health Care Practitioner** LAST NAME (**Please Print and circle one:** MD, DO, NP, PA) | FIRST NAME | Signature |
|---|---|---|
| Address | Tel. No. ( __ __ __ ) __ __ __ - __ __ __ __ | Fax. No ( __ __ __ ) __ __ __ - __ __ __ __ |
| E-mail address | Cell phone ( __ __ __ ) __ __ __ - __ __ __ __ | |
| NYS License No **(Required)** ___ ___ ___ ___ ___ ___ | NPI No. __ __ __ __ __ __ __ __ __ __ | Date __ __ / __ __ / __ __ __ __ |

# 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.**

## 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 |
|---|---|---|---|---|
| **School ATSDBN/Name** | | | Borough | District |

| **Parent/Guardian's Name** (Print) | **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** | **Alternate Contact's 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 e-mail.

FOR PRINT USE ONLY