Department of Health and Mental Hygiene | **Department of Education**

Cheryl Lawrence, MD, FAAP
Medical Director

Office of School Health
30-30 47th Avenue,
Long Island City, NY
11101

June 2023

Dear Parent or Guardian,

New York City has updated the school immunization requirements for the 2023-2024 school year. A list of the vaccine requirements for 2023-2024 is included with this letter. Vaccines protect children from getting and spreading diseases; they are required to attend school.

Before the school year begins, you must submit proof of immunization or blood test results that show immunity (see below) for your child if they are attending childcare or school. **All students in childcare through grade 12** must meet the requirements for:

- The DTaP (diphtheria-tetanus-pertussis), poliovirus, MMR (measles-mumps-rubella), varicella and hepatitis B vaccines.

Children under age 5 who are enrolled in childcare and pre-kindergarten (pre-K) must also meet the requirements for:

- The Hib (*Haemophilus influenza* type b) and PCV (pneumococcal conjugate) vaccines.
- The influenza (flu) vaccine: children must receive the flu vaccine by December 31, 2023 (preferably, when it becomes available in early fall).

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

- The Tdap (tetanus-diphtheria-pertussis) booster and MenACWY (meningococcal conjugate) vaccines.

Blood tests that show immunity to measles, mumps, rubella, varicella, or hepatitis B also meet the requirements (polio labs only if done before September 2019).

Please take the time this summer to review your child's immunization history with your child's healthcare provider. Their provider can tell you whether additional doses of one or more vaccines are required for your child to attend childcare or school this year. **Please note**: If your child received doses of vaccine BEFORE the minimum age (too early), those doses do NOT count toward the number of doses needed.

If you have questions about these 2023-2024 requirements, please contact your childcare center or school's administrative office.

Sincerely,

Cheryl Lawrence

Cheryl Lawrence, MD, FAAP
Medical Director
Office of School Health

Is Your Child Ready for Child Care or School?

2023-2024 School Year

Learn about required vaccinations in New York City.

All students ages 2 months up to 18 years in New York City must get the following vaccinations to go to childcare or school. Review your child's vaccine needs based on their grade level this school year. The number of vaccine doses your child needs may vary based on age and previous vaccine doses received. Your child may need additional vaccines or vaccine doses if they have certain health conditions or if previous doses were given too early. Blood tests that show immunity to measles, mumps, rubella, varicella, or hepatitis B also meet the requirements (polio immunity is only acceptable if the lab test was done before September 2019).

VACCINATIONS	CHILD CARE, HEAD START, NURSERY, 3K OR PRE-KINDERGARTEN	KINDERGARTEN - Grade 5	GRADES 6 -11	GRADE12
Diphtheria , tetanus, and pertussis (DTaP)	**4 doses**	**5 doses** **or 4 doses** ONLY if the fourth dose was received at age 4 years or older **or 3 doses** ONLY if the child is age 7 years or older and the series was started at age 1 year or older	**3 doses**	
Tetanus, diphtheria and pertussis booster (Tdap)			**1 dose** is required at 11 years or older when entering grades 6 - 12 (in compliance until age 11 years)	
Polio (IPV or OPV)	**3 doses**	**4 doses** **or 3 doses** if the third dose was received at age 4 years or older		
Measles, mumps and rubella (MMR)	**1 dose**	**2 doses**		
Hepatitis B	**3 doses**	**3 doses**	**3 doses** **or 2 doses of adult hepatitis B vaccine** (Recombivax HB®) if the doses at least 4 months apart between ages of 11 through 15 years	
Varicella (chickenpox)	**1 dose**	**2 doses**		
Meningococcal conjugate (MenACWY)			**Grade 6: Not applicable** **Grades 7-11: 1 dose**	**Grade 12: 2 doses** **or 1 dose** if the first dose was received at age 16 years or older
***Haemophilus influenzae* type b conjugate (Hib)**	**1 to 4 doses** Depends on child's age and doses previously received			
Pneumococcal conjugate (PCV)	**1 to 4 doses** Depends on child's age and doses previously received			
Influenza	**1 dose**			

Talk to your health care provider if you have questions.

For more information call **311** or visit **nyc.gov/health** and search for **student vaccines.**

NYC | Department of Health & Mental Hygiene | Department of Education

NYC Health | Department of Health and Mental Hygiene | Department of Education

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex	Date of Birth (Month/Day/Year)
			☐ Female ☐ Male	___/___/___

Child's Address

Hispanic/Latino? ☐ Yes ☐ No

Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough	State	Zip Code	School/Center/Camp Name	District Number
				___ ___

Phone Numbers
Home
Cell
Work

Health Insurance (including Medicaid)? ☐ Yes ☐ No

☐ Parent/Guardian ☐ Foster Parent

Last Name **First Name**

Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma (check severity and attach MAF): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes (attach MAF)
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis (latent infection or disease)
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

Medications (attach MAF if in-school medication needed)
☐ None ☐ Yes (list below)

PHYSICAL EXAM Date of Exam: ___/___/___

Height	_____ cm	(___ ___ %ile)
Weight	_____ kg	(___ ___ %ile)
BMI	_____ kg/m²	(___ ___ %ile)
Head Circumference (age ≤2 yrs)	_____ cm	(___ ___ %ile)
Blood Pressure (age ≥3 yrs)	_____ / _____	

General Appearance:

☐ Physical Exam WNL

Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl
☐	☐	Psychosocial Development	☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐ Abdomen
☐	☐	Language	☐	☐	Dental	☐	☐	Lungs	☐	☐ Genitourinary
☐	☐	Behavioral	☐	☐	Neck	☐	☐	Cardiovascular	☐	☐ Extremities

Nl	Abnl	
☐	☐	Skin
☐	☐	Neurological
☐	☐	Back/spine

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs)

Validated Screening Tool Used? ☐ Yes ☐ No

Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes (list below)

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment (at each well child exam, age 6 mo-6 yrs)	___/___/___	☐ At risk (do BLL) ☐ Not at risk
Child Care Only		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ Nl ☐ Abnl ☐ Referred
OAE	___/___/___	☐ Nl ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ Nl ☐ Abnl ☐ Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ Nl ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay ☐ Yes ☐ No

Urgent need for dental referral (pain, swelling, infection) ☐ Yes ☐ No

Dental Visit within the past 12 months ☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

								IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/17/2023		Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Polio 3	___/___/___

Tdap	___/___/___	___/___/___	___/___/___	
MMR	___/___/___	___/___/___	___/___/___	
Varicella	___/___/___	___/___/___	___/___/___	
Mening ACWY	___/___/___	___/___/___	___/___/___	
Hep A	___/___/___	___/___/___	___/___/___	
Rotavirus	___/___/___	___/___/___	___/___/___	
Mening B	___/___/___	___/___/___	___/___/___	
Other _____	___/___/___	___/___/___	___/___/___	

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** (list) **ICD-10 Code**

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (specify) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature

Date Form Completed ___/___/___

DOHMH ONLY **PRACTITIONER I.D.**

Health Care Practitioner Name and Degree (print)

Practitioner License No. and State

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name

National Provider Identifier (NPI)

Address City State Zip

Date Reviewed: ___/___/___

I.D. NUMBER

REVIEWER:

Telephone Fax Email

FORM ID#

Attach student photo here

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 1st 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
- 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 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 pr

Student SkillLevel (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**

Please return to School Nurse/School Based Health Center. 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/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

Confidential information should not be sent by email

FOR PRINT USE ONLY

Attach student photo here

ASTHMA 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 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle Initial:_____ Date of birth: _____

Sex: ☐ Male ☐ Female OSIS Number: _____ DOE District: ____ Grade/Class: _____

School (include: ATS DBN/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
- ☐ Unknown

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	
Excessive Short Acting Beta Agonist (SABA) use (daily or > 2 times a week)?	☐ Y	☐ N	☐ U	

Home Medications (include over the counter) ☐ **None**

☐ Reliever: _____ ☐ Controller: _____ ☐ Other: _____

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 ability to self-administer the prescribed medication effectively during school, field trips, and school- Sponsored events. Practitioner's Initials: _____

Quick Relief In-School Medication

**** If in Respiratory Distress: call 911 and give albuterol 6 puffs: may repeat Q 20 minutes until EMS arrives!**

☐ Albuterol [Only generic Albuterol MDI w/ individual spacer is provided by school; this will be used if prescribed medication below is unavailable)
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.

Other Quick Relief Medication:
- ☐ Other Albuterol Dosing: Name:_____ Strength : _____ Dose:____ puffs every ____ hours. *If not symptom-free within 20 mins may repeat ONCE*
- ☐ Airsupra (albuterol & budesonide) Strength:_____Dose____puffs PRN every ___hrs. *If not symptom-free within 20 mins may repeat ONCE*
- ☐ Symbicort (formoterol & budesonide) Strength : _____ Dose:_____ puffs every _____min or ____hrs. ☐ *May repeat ONCE PRN*
- ☐ Albuterol with ICS : ☐ Albuterol ___puffs followed by Flovent _____ puffs every _____hrs. *If not symptom-free in 20 mins may repeat ONCE*
  ☐ Albuterol ___puffs followed by Qvar_____ puffs every ___hrs. *If not symptom-free in 20 mins may repeat ONCE*
- ☐ Albuterol MDI _____puffs followed by ICS (Name) _____ Strength: _____puffs every____ hrs

☐ URI Symptoms/Recent Asthma Flare: 2 puffs @noon for 5 school days when directed by PCP
Name:_____ Dose: _____ puffs/ _____ AMP q _____ hrs.

☐ **Pre-exercise**: Name:_____ Dose: _____ puffs/ _____ AMP 15-20 mins before exercise.

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
Standing Daily Dose: ____ puff (s) ☐ one **OR** ☐ two time(s) a day Time: _____ AM and _____PM

☐ Symbicort (provided by parent). Standing Daily Dose: ____ puff (s) ☐ one **OR** ☐ two time(s) a day Time: _____ AM and _____PM Special Instructions:_____

☐ Other ICS (provided by parent) Standing Daily Dose:
Name: _____Strength: _____ Dose: ____Route: _____Frequency: ☐ one OR ☐ two time(s) a day Time: ____AM &____PM

Health Care Practitioner

Last Name (Print):_____ First Name (Print): _____ ☐MD ☐DO ☐NP ☐PA

NYS License # _____ NPI # : _____ Signature: _____ Date: _____

Completed by Emergency Department Medical Practitioner: ☐Yes ☐ No (ED Medical Practitioners will not be contacted by OSH/SBHC Staff)

Address: _____ E-mail address: _____

Tel: _____ FAX: _____ Cell Phone: _____

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

FORMS CANNOT BE COMPLETED BY A RESIDENT
INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

PARENTS MUST SIGN PAGE 2 →

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year 2023-2024

Please return to School Nurse/School Based Health Center. 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/School Based Health Center (SBHC) 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 Office of School Health (OSH) giving my child stock medication in the event my child's asthma medicine is not available.
   - I must **immediately** tell the school nurse/SBHC provider 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 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. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse/ SBHC 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 the O. 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 Section 504 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/SBHC will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine ina 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 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 ☐ OSH Asthma Case Manager *(For supervised students only)*

Signature and Title (RN OR MD/DO/NP):_____

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

Confidential information should not be sent by email

FOR PRINT USE ONLY

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 I Office of School Health I School Year **2023-2024**

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

Student Last Name: _____ First Name: _____ Middle: _____ Date of birth: _____

OSIS Number: _____ Sex: ☐ Male ☐ Female

School (include name, number, address, and borough): _____ DOE District: ____ Grade: ____

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

☐ 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)

☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events - Practitioner's Initials: _____

In School Instructions

☐ Standing daily dose – at _____ and _____ **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/nurse-trained staff must administer

☐ 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)

☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events - Practitioner's Initials: _____

In School Instructions

☐ Standing daily dose – at _____ and _____ **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/nurse-trained staff must administer

☐ 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)

☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events - Practitioner's Initials: _____

In School Instructions

☐ Standing daily dose – at _____ and _____ **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 Last Name: _____ First Name: _____ Signature: _____

Please select one: ☐ MD ☐ DO ☐ NP ☐ PA

Address: _____ E-mail address: _____

Tel. No: _____ FAX No: _____ Cell Phone: _____

NYS License No (Required): _____ NPI No: _____ Date: _____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

Rev 3/23

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 I Office of School Health I School Year 2023-2024

Please return to School Nurse/School Based Health Center. 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/school based health center (SBHC) 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/SBHC provider 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/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 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 Section 504 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/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.
  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 (ATS DBN/Name): _____ Borough: _____ District: _____

Parent/Guardian Name (Print): _____ Parent/Guardian's Email: _____

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Address: _____

Telephone Numbers: Daytime: _____ Home_____ Cell Phone: _____

Alternate Emergency Contact:

Name: _____ Relationship to Student: _____ Phone Number:_____

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 as per OSH contact with prescribing health care practitioner: ☐ Clarified ☐ Modified