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, MD, FAAP
Medical Director
Office of School Health
Is Your Child Ready for Child Care or School?
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).

<table>
<thead>
<tr>
<th>VACCINATIONS</th>
<th>CHILD CARE, HEAD START, NURSERY, 3K OR PRE-KINDERGARTEN</th>
<th>KINDERGARTEN - Grade 5</th>
<th>GRADES 6-11</th>
<th>GRADE 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, tetanus, and pertussis (DTaP)</td>
<td>4 doses</td>
<td>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</td>
<td>3 doses</td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria and pertussis booster (Tdap)</td>
<td></td>
<td>1 dose (for children ages 11 years or older who enter grades 6-12; compliance until age 11 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio (IPV or OPV)</td>
<td>3 doses</td>
<td>4 doses or 3 doses if the third dose was received at age 4 years or older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps and rubella (MMR)</td>
<td>1 dose</td>
<td>2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3 doses</td>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (chickenpox)</td>
<td>1 dose</td>
<td>2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal conjugate (MenACWY)</td>
<td></td>
<td>Grade 6: Not applicable</td>
<td></td>
<td>Grade 12: 2 doses or 1 dose if the first dose was received at age 16 years or older</td>
</tr>
<tr>
<td>Haemophilus influenza type b conjugate (Hib)</td>
<td>1 to 4 doses Depends on child's age and doses previously received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal conjugate (PCV)</td>
<td>1 to 4 doses Depends on child's age and doses previously received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
### 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  [ ] No

- If yes, system affected:  [ ] Respiratory  [ ] Skin  [ ] GI  [ ] Cardiovascular  [ ] Neurologic

**Treatment:** ___________________________

- **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

#### 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

- [ ] 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 an antihistamine after epinephrine administration (order antihistamine below)**

#### Select In-School Medications

**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
  - Benadryl mg po q6 hours pm
  - Name: ___________________________
  - Preparation/Concentration: ___________________________
  - Dose: ___________________________
  - PO Q4 hours Q6 hours Q12 hours pr

**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 pm

**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 ________________________ Received by - Name: ________________________ Date: ____________

Returned 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
ASTHMA MEDICATION ADMINISTRATION FORM

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

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 NAEP Guidelines)

□ Well Controlled

□ Not Controlled / Poorly Controlled

□ Unknown

Severity (see NAEP 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 □ Other: ________________

□ 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 ______ hours. If not symptom-free within 20 mins may repeat ONCE

□ Symbicort (formoterol & budesonide) Strength: ________________ Dose: ______ puffs every ______ min or ______ hours. □ May repeat ONCE PRN

□ Albuterol with ICS: □ Albuterol ______ puffs followed by Flovent ______ puffs every ______ hours. If not symptom-free in 20 mins may repeat ONCE

□ Albuterol ______ puffs followed by Qvar ______ puffs every ______ hours. If not symptom-free in 20 mins may repeat ONCE

□ Albuterol MDI ______ puffs followed by ICS (Name) ______ puffs every ______ hours

□ 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 NAEP Guidelines)

□ Fluticasone [Only Flovent® 110 mcg MDI is provided for school usage] □ Stock □ Parent Provided

Standing Daily Dose: ______ puffs (s) □ one OR □ two time(s) a day Time: ______ AM and ______ PM

□ Symbicort (provided by parent) Standing Daily Dose: ______ puffs (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 and ______ 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

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 medication 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 medication 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.
     o 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 in a 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
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: ____________________________ Date: ________________

NYS License No (Required): ____________________________ NPI No: ____________________________

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: ___________________________ 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

Confidential information should not be sent by email.