School Health Program

Office of School Health
Department of Education
Department of Health and Mental Hygiene

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Office of School Health

Keep students healthy so they can come to school and learn!
Office of School Health (OSH)

- The OSH is a combined program of the Department of Education and the Department of Health and Mental Hygiene.

- The goal and responsibility of this office is to promote the health and provide quality health services to students attending the New York City schools.
OSH Health Services

Include:

- preventative health teaching
- preventative health screening
- health education
- case management of chronic health problems
- direct services including urgent care and medication administration and procedures, i.e. catheterization and diabetes monitoring
- referral for care and follow-up to promote ongoing effective treatment
- case identification
- assessment of identified child’s function and physical health status in collaboration with the child’s parent and health care provider
- Developing individual health and emergency care plans
OSH Team

Adolescent/Reproductive Health
Mental Health
Nursing
Medical
Vision
Dental
Wellness
Related Services
OSH School Team

School Nurses
School Physicians
Nursing Directors
Supervising Nurses
Supervising Physicians
Nurse Practitioners
Public Health Advisors/Assistants
OSH Medical Organization

- Medical Director
- Deputy Medical Director
- Supervising Physicians
- Field Physicians
OSH Nursing services

Approximately 1,800 school nurses citywide

<table>
<thead>
<tr>
<th>School</th>
<th>Nursing Health Services</th>
<th>Other Health service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Elementary &gt;200 Students</td>
<td>OSH nurses</td>
<td></td>
</tr>
<tr>
<td>Public Middle School</td>
<td>OSH nurse if skilled nursing need</td>
<td>Public Health Advisor if no skilled nursing need</td>
</tr>
<tr>
<td>Public High School</td>
<td>OSH nurse if skilled nursing need</td>
<td>No Service if no skilled nursing need</td>
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<tr>
<td>D75 program</td>
<td>OSH; DOE nurse based on skilled nursing need</td>
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<tr>
<td>Non-Public School &gt;200 students</td>
<td>OSH; DOHMH nurse</td>
<td></td>
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<tr>
<td>Charter</td>
<td>Same as public</td>
<td></td>
</tr>
<tr>
<td>SBHC site</td>
<td>Generally no OSH nurse is assigned</td>
<td>NP or PA from SBHC</td>
</tr>
<tr>
<td>Public, Non Public, Pre-K with &lt;200 students and a 504 need</td>
<td>OSH nurse is assigned</td>
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Medical Room Standards

To ensure student safety and privacy School Health has set minimum standards for these rooms:

1) Adequately sized room (in general, at least 200 square feet)
2) Sink with hot and cold running water
3) No through traffic
4) Floor to ceiling walls
5) Internet access and adequate electrical power for computer
6) Telephone line and adequate electrical outlets
7) Functioning Fax line
8) Adequate heating, air conditioning, lighting and ventilation
9) Internal bathroom (or dedicated bathroom within a few steps of the medical room)
OSH School Nurse and Physician Team

- The school nurse and physician (clinical team) work together to promote optimal health and safety for New York City children

- School Nurse:
  - schedules appointments for students to be seen by the doctor
  - helps alert the school doctor about students having difficulties during school due to medical conditions

- The school physician helps nurse with medical management questions

- The clinical team shares community resources with each other
OSH School Nurse and Physician Team

- Identify community partners and coordinate resources to improve the health of students
  - Community Based Organizations
  - City Agencies
    - The Mayor’s Office
    - Administration for Children’s Services
    - Other DOHMH programs
    - Other DOE programs
  - School-based Health Centers and Mental Health Clinics
  - Hospitals and Health Centers
Role of the School Health Physician

- Teamwork with school nurse
- Physical examinations
- Case management for students with chronic illnesses
- Liaison for community providers
- Resource to school staff
- Public health role
- Manage communicable disease outbreaks in schools
- Collaboration with other agencies
Role of the School Health Physician

- Screen and refer
  - School Health Physicians are not a substitute for the primary care or specialty physician

- Can assist with prescriptions for certain medications to be taken in school, most notably Asthma medications:
  - Albuterol and Flovent
  - This is done on a case by case basis and in conjunction with the student’s family and primary care physician

- Do not:
  - write prescriptions for medications outside of school
  - give immunizations
  - perform exams for Individual Education Plans (IEPs), after school programs, or summer camps
OSH Physician Services

- BC/BE licensed physicians are trained in children’s health and knowledge in public health practices
- 80 physicians and growing
- Assigned to regional/district elementary, junior high schools, and/or high school
- Visit a panel of schools throughout the year
- Some also work with local hospitals or clinics
OSH Physician services

- Address infectious disease outbreaks
  - Examples: Pertussis, Measles, or Mumps
- Enforce local and state medical codes
- Implement Office of School Health programs
- Serve as public health resource for school and community
- Address environmental concerns
OSH Physician services

- Case management
  - Review of Medication Administration Forms as it relates to:
    - Asthma
    - Diabetes
    - Allergies/Anaphylaxis
    - Seizures
    - Other
  - Ensure access to health services so that students may achieve their best in school
    - Review 504 accommodations for special cases
    - Link students to primary and specialty care
    - Advocate for student needs
OSH Physician services

- Meet with principal and school staff about school health needs
- Identify challenges in schools that have an impact on student health
- Provide health education for school staff, students, and families
- Act as an advocate for students and families
- Works in collaboration with students, families, and the primary care provider

THE DOCTOR IS IN
OSH physician services

- Help students find a primary care provider, if needed
- Discuss with providers and caregivers about students’ medical needs during school hours
  - Communicate the occurrence of medical events
  - Provide recommendations on prevention and ongoing in-school care
- Refer students for medical evaluations as indicated
OSH Nursing Services

- The program works best when there is a strong and effective relationship between the nurse and the principal or designee.

- Nurses are expected to contribute their time and expertise to the school community.

- Principals are encouraged to participate in the selection of the nurse and the non-clinical aspects of the nurse’s evaluation.

- Nurses may request to transfer to a vacant school after completing one academic year.
Role of the school health nurse

- Engages in case identification, referral and case management activities in conjunction with the school health team and community providers

- Assesses the identified child’s function and physical health status, in collaboration with the child’s parent and health care provider

- Develops individual health and emergency care plans
OSH Nursing Services

- Nursing practice is governed by the NYS Nurse Practice Act and the State Education Department.

- Medically-related School Health Services can only be provided by a professional Registered Nurse in a school setting and/or on the bus to and from school.

- Medication Administration Forms (MAF’s) are received from primary provider each academic year for the nurse to administer in school setting.
HEALTH SERVICES:
MEDICATION & PROCEDURES

- Administer Oral Medication
- Administer medication through Inhaler or nebulizer
- Application of ear, eye or nose drops
- Application of topical creams or ointments for chronic conditions
- Injections (SC or IM)
- Blood Glucose Monitoring
- Dressing Changes
- Postural Drainage
- Central Venous Line
- Management of Insulin Pumps
- Rectal Medications
- Tracheostomy Care
- Nasogastric tube care and feedings
- Gastrostomy feeding
- Catherization (urinary)
- Oral/Pharyngeal suctioning
- Oxygen administration
- Pulse Oximetry monitoring
- Ostomy care
- Chest clapping
- Percussion
OSH Nursing Nurses

- Will request a meeting with the Principal and the Faculty at the beginning of each school year.

- Will inform teacher of health information needed to keep student safe in school and/or special accommodations recommended by private care provider as needed.

- May also request a formal appointment to review health status of students with teacher during the school year and teacher may share observations with nurse.
Walk In Visits

- Teacher Nurse Referral must be completed and accompany student to the medical room

- If student is to be picked up from school, the student will wait in classroom or general office unless condition warrants monitoring by OSH staff.

- Minor issues such as paper cuts may be addressed by teacher in classroom
Walk In Visits

- DOE accident reports/incident reports will be completed by staff member witnessing the accident.

- Students who are waiting to be picked up by parents who do not need nurse observation should be sent to the main office or classroom for parent pick-up and discharge.
Walk In Visits

The school nurse will contact parents by phone and/or send home a referral slip (SH10 or a 12s) to the parent informing them of the visit and if need for follow up.
OSH Nursing Services

Documentation:

- Automated School Health Record (ASHR)
- 103s (paper record)
- Log Book
- Medication Administration records
- Confidentiality
OSH Nursing services

- **Lunch Hours:**
  - DOHMH nurses are entitled to one hour unpaid lunch and may leave the building. Staff will notify the general office when leaving for and returning from lunch. If the DOHMH nurse is out to lunch, there should be a designated staff member to handle calls to parents if necessary. In addition, the Principal and/or designee can oversee self-directed students administer medications such as an inhaler for an asthma episode.
  - DOE nurses have one half hour lunch. They remain in the building and will respond to emergencies.
Training of unlicensed persons as per New York State Education Office of the Professions:

Nurse can train unlicensed personnel in:

- Epi-pen administration for a student with an MAF for anaphylaxis - as per Chancellor Regulation A715, principal will appoint DOE staff who will be trained to administer epinephrine in an emergency if the school nurse is not available.

- Glucagon Administration for a student with Diabetes - MAF (Central Office approval upon request; conducted on a case by case basis on a voluntary basis)

- Blood glucose monitoring (Central Office approval)
Physical Examinations

- A New Admission Examination (CH205) is required for ALL entering students
- All students are required to have a physical exam upon entrance to school. This examination is completed on a CH 205 Form by the student’s health care provider or an OSH physician
  - NYC Public Health Code Article 49.05 and the Department of Education Chancellor’s Regulations A-701
Physical Examinations

- This exam **should be done** by the student’s primary care provider.

- CH 205’s are to be given to the school nurse. The school may retain a copy of the CH 205’s, however all original CH205’s must be provided to the school nurse. These forms contain confidential medical information.

- If a student can not access a provider, then a School Health Physician may perform the physical exam in their school.
Physician Sessions

- OSH physicians are assigned to conduct an physician session at school for exams, case management referrals, and record review as per the NYC Health Code

- Students who have not submitted a physical exam may be scheduled for MD session

- Nurse will inform principal and teacher of date and time student is scheduled to attend

- Student’s 104S will be needed for MD session
Physical Examinations

- Pre-participation Sports Examinations
  - Required for participation in interscholastic sports including Public School Athletic League (PSAL) activities

- Working Paper Examinations
  - Required for job-seeking students under 18 years old
  - These exams should be done by the student’s primary care provider

- If a student can not access a provider, then a School Health Physician may perform the physical exam in their school.
CHILD & ADOLESCENT HEALTH EXAMINATION FORM
NYH COMMUNITY & FAMILY Services, Department of Education

CH205 - Physical Examination Form
Communicable Diseases

- Any student with a rash of unknown origin must be sent to the medical room for assessment.

- If there is a concern of a communicable disease occurrence for a student the principal/designee should contact the school nurse who will loop in the supervising physician and communicate the concern to and work with the communicable disease liaison.

- The nurse will follow OSH/ Bureau of Communicable Disease guidelines.

- Nurse will inform principal if precautions are required and will provide letters and fact sheets to the principal for distribution as needed.
Communicable Diseases

- All students’ immunizations should be up to date. If student has not had an immunization and there is an outbreak of that disease in school, student may need to be excluded for incubation period.

- If there is a concern about a staff person, Principal calls BOI or BCD directly. OSH is not privy to personal health information of school staff.

- 1) Bureau of Immunization (for vaccine preventable diseases) 347-396-2402.

- 2) Bureau of Communicable Disease 347-396-2600
EMERGENCIES

- Each school has trained personnel to respond to emergencies and conduct CPR.

- If CPR is needed, a code is called and defibrillator will be brought to the site by trained school staff.

- The school nurse and physician will respond to emergencies unless attending to another student with urgent needs.

- The nurse cannot always respond immediately. For this reason, the school nurse **should not** be the primary responder for emergencies.
EMERGENCIES

- The clinical team is primarily assigned to schools to care for the health needs of students and as such may not administer medication and or treatments to school staff.

- In the event of an evacuation, the school nurse will set up his or her station in a predetermined location in close proximity to command center.

- The school nurse cannot go in the ambulance with a student.
The school nurse/physician will call 911 if warranted based on their clinical assessment. However, the school nurse will inform the principal that 911 was activated.
In some schools every student with a minor injury (e.g. a paper cut) is sent to the medical room. This is not medically (or legally) necessary as students lose instruction time and the nurse cannot perform other important functions.
School Trips

- Students receiving nursing/medication services who are:

1) **Nurse dependent** may require a nurse on school trips if the time of medication administration cannot be adjusted or if there is a prn (as needed) order.

2) **Supervised** may not self-carry but may self-administer medication in a supervised setting.

3) **Independent** may self-carry and self-administer medication if the school receives a written order from the provider indicating such and the school receives written parent consent.
School Trips

- Independent Students:
  - can self-carry and self-administer his/her own medication on a school trip
  - a nurse is not required
School Trips

- **Supervised Students:**
  - is able to administer his/her own medication, with supervision
  - a nurse is not needed to accompany a supervised student on a school trip
  - may be assisted by trained unlicensed voluntary school staff to self-administer his/her own medications if the student is able to direct an adult regarding his/her medication needs
  - the school may request that the parent accompany a supervised student on the trip
  - If the parent cannot accompany the student and the time of the medication cannot be adjusted within the acceptable window to obviate the need for assistance on the trip, a staff member may volunteer to carry and assist the student in taking his or her own medication
  - The volunteer staff member will be instructed in how to assist the student by the school nurse.
School Trips

- **Nurse Dependent Student:**
  - a student is nurse dependent if he/she cannot self-administer his/her own medication, even with supervision
  - A trip nurse will be requested if the parent is unable to attend
  - the school may request that a parent attend the trip
  - If a trip nurse or parent is not available to attend the trip, the Office of School Health and Department of Education allow a parent to designate, in writing, another adult, who may be a friend or family member, to administer the medication
  - This person may not be an employee of the school.
  - Appointment of a designee is the choice of the parent and school personnel may not require a parent to appoint one.
School Trips

- School/Teacher should notify nurse of all school trips for students receiving nursing/medication services well in advance of the trip so the appropriate plan can be developed.

- Overnight trips need more advance notice (at least 60 days prior notice) to allow time to coordinate amending orders.

- The trip nurse will be requested but is not guaranteed. An alternate plan must be developed in case there is no trip nurse available.
School Trips

If a student cannot attend a trip because the medication needs of the student cannot be met in accordance with the guidelines contained in this document, in accordance with DOE policy and applicable law, **the trip must be cancelled or postponed** until such time as the medication needs can be met.
New York State Education Law only permits appropriately licensed health professionals to administer medication to students in a school, with limited exceptions. Under Title Eight of Education Law, such professionals include but are not limited to: physicians, nurse practitioners (NP), physician assistants (PA), registered professional nurses (RN), and licensed practical nurses (LPN) under the direction of an RN.
Section 504 of the Rehabilitation Act of 1973

Students determined to have a disability under Section 504 of the 1973 Rehabilitation Act, who do not qualify for special education may also receive health services by a nurse if requested and documented by the student’s health care provider on the **MAF/Health Accommodations Forms.**
Section 504 Services

- DOE/OSH requires that a new MAF/Health and Accommodations Form be submitted yearly.

- Schools are responsible for informing parents of the availability of Section 504 accommodations.

- The forms are made available at the regions, in school medical rooms and on the DOE’s web site:

  - [www.nycboe.net/offices/spss/cpsb.asp](http://www.nycboe.net/offices/spss/cpsb.asp)
Let's look at the 2018-2019 MAF’s... 

Original MAF’s are to be given to the school nurse. These forms contain confidential medical information.
MEDECATION ADMINISTRATION FORM  
THIS FORM SHOULD NOT BE USED FOR ASTHMA OR ALLERGY MEDICATIONS  
Provider Medication Order Form | Office of School Health | School Year 2018-2019  
DUE: JULY 15th. Forms submitted after July 15th may delay processing for new school year.  

Student Last Name ___________________________ First Name ___________________________ Middle ___________________________ Date of birth _____/____/____ M.M.D.D.YYYY  
□ Male □ Female  
OSIS Number ___________________________ School (Include name, number, address and borough) ___________________________ DOE District ___________________________ Grade ___________________________ Class ___________________________  

HEALTH CARE PRACTITIONERS COMPLETE BELOW  

1. Diagnosis: ___________________________ ICD-10 Code □ __ __ __  
Medication: ___________________________ Generic and/or Brand Name ___________________________  
Preparation/Concentration: ___________________________ Route: ___________________________  
Dose: ___________________________  
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 self-carry/self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES)  
I attest student demonstrated ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.  
Practitioner's initials ___________________________  

2. Diagnosis: ___________________________ ICD-10 Code □ __ __ __  
Medication: ___________________________ Generic and/or Brand Name ___________________________  
Preparation/Concentration: ___________________________ Route: ___________________________  
Dose: ___________________________  
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 self-carry/self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES)  
I attest student demonstrated ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.  
Practitioner's initials ___________________________  

3. Diagnosis: ___________________________ ICD-10 Code □ __ __ __  
Medication: ___________________________ Generic and/or Brand Name ___________________________  
Preparation/Concentration: ___________________________ Route: ___________________________  
Dose: ___________________________  
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 self-carry/self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES)  
I attest student demonstrated ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.  
Practitioner's initials ___________________________  

HOME Medications (include over-the-counter) ___________________________  

Health Care Practitioner (Please Print) ___________________________ LAST NAME ___________________________  
FIRST NAME ___________________________ Signature ___________________________  
Address ___________________________  
Tel. No. (______) ___________________________ Fax No. (______) ___________________________  
E-mail address ___________________________  
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 2/18  
PARENTS MUST SIGN PAGE 2 ➔
MEDICATION ADMINISTRATION FORM
This form should not be used for asthma or allergy medications
Provider Medication Order Form | Office of School Health | School Year 2018–2019
Due: July 15th. Forms submitted after July 15th may delay processing for new school year.
PARENTS/GUARDIANS FILL BELOW

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 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 get another medicine for my child to use when he or she is not in school or is on a school trip.
   - 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 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 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 a new MAF (whichever is earlier).
   - 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 Student Accommodation Plan. This plan will be completed by the school.
   - 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.
   - If the school nurse is unavailable, I may be notified to come to school to give my child medicine.

FOR SELF-ADMINISTRATION OF MEDICINE:
1. 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 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.
2. I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

NOTE: It is preferred that you send medication and equipment for your child on a school trip and for off-site school activities.

Student First Name: ____________________________ Last Name: ____________________________ Date of Birth: ______/____/_____

Print Parent/Guardian's Name: ____________________________ 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: ____________________________ Contact Telephone Number (_____,_____,_____)

For Office of School Health (OSH) Use Only
OSHIS Number: ____________________________

Received by: ____________________________ Date:_____/_____/______ Reviewed by: ____________________________ 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: □ Modified □ Not Modified

*Confidential information should not be sent by email.
Asthma Medication Administration Form

Student Last Name | First Name | Date of Birth | Gender | Grade:Class | OSIS # | DOE District | School Name, Number, Address, and Borough

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

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown):
- History of near-death asthma requiring mechanical ventilation
- History of life-threatening asthma (loss of consciousness or hypotension)
- History of asthma-related PICU admissions (ever)
- Received oral steroids within past 12 months
- History of asthma-related ER visits within past 12 months
- History of asthma-related hospitalizations within past 12 months
- History of food allergy or eczema: specify:

Student Skill Level (Select the most appropriate option):
- Nurse-Dependent: Student must administer medication
- Supervised: Student administers medication under adult supervision
- Independent: Student administers medication

Home Medications (Include over the counter):
- Reliever
- Controller
- Other

Quick Relief In-School Medication (Select ONE):
- Albuterol MDI
  - Ventolin® MDI can be provided by school for shared usage (plus individual spacer):
    - MDI w/ spacer
    - DPI
  - Other Name:
  - Dose: Route: Time Interval: ___ hrs

Controller Medications for In-School Administration:
- Fluticasone MDI
  - PErformer® 110 mcg MDI can be provided by school for shared usage
    - MDI w/ spacer
    - DPI
  - Other Name:
  - Dose:
  - Route:
  - Time Interval: ___ hrs

In-School Instructions (Check all that apply):
- Standard Order: Give 2 puffs/1 AMP q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath ("asthma flare symptoms"). Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE.
- URI Symptoms or Recent Asthma Flare (Within 5 days): 2 puffs/1 AMP @ noon for 5 days.

Health Care Practitioner (Please Print Name):

Signature:

Date: ___ / ___ / ________

Address:

Tel.: ___ Fax: ___

Email Address:

NYS License #: (Required)

PARENTS MUST SIGN PAGE 2 ➔
ASTHMA MEDICATION ADMINISTRATION FORM
ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year 2018-2019
DUE: JULY 15th. Forms submitted after JULY 15th may delay processing for new school year.

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 my child's medicine and equipment, including non-Ventolin inhalers.
   - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box.
3. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
   - 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.
4. OSH and its agents involved in providing the above health service(s) to my child's medicine are relying on the accuracy of the information in this form.
5. By signing this medication administration form (MAF), the Office of School Health (OSH) may provide health services to my child.
6. These services may include a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
7. 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 a new MAF (whichever is earlier).
8. When this medication order expires, I will give my child's school nurse 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 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 medication. The OSH health care practitioner may decide if the medication orders need to be changed. The OSH health care practitioner will fill out a new MAF so my child can continue to receive health services through OSH. OSH 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.
9. 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 Student Accommodation Plan. This plan will be completed by the school.
10. 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 professional, nurse, or pharmacist who has given my child health services.
11. If the school nurse is unavailable, I may be notified to come to school to give my child medicine.

FOR SELF ADMINISTRATION OF MEDICINE:
- I certify/confirn 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 medicine 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 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 medicine if my child is temporarily unable to carry and give him or herself medicine.
- I certify/confirn 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 medicine is not available.

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: _______ _______ _______

Parent/Guardian Print Name: ___________________________

Date Signed: _______ _______ _______ Parent/Guardian's Address: ___________________________

Cell Phone: (______) - _______ - _______ Other Phone: (______) - _______ - _______ Email: ___________________________

Alternate Emergency Contact Name: ___________________________
Emergency Contact Phone: (______) - _______ - _______

For OFFICE OF SCHOOL HEALTH (OSH) Use Only

OSIS Number: ___________________________

Received By Name: _______ Date: _______ Reviewed By Name: _______ Date: _______

Services Provided By: School-Based Health Center OSH Public Health Advisor (For supervised students only)

Revisions per Office of School Health after consultation with prescribing practitioner: [ ] Modified [ ] Not Modified

Signature and Title (RN OR MDDONP): ___________________________

*Respiratory distress includes: breathing problems, chest tightness, coughing, cyanosis, labored breathing, nasal flaring, accessory respiratory muscle use, abdominal breathing, shallow rapid breathing, muffled speech, wheezing throughout expiration and inspiration or decreased or absent breath sounds, apnea, drowsiness, confusion or exceptionally quiet appearance.

SIGN HERE: ___________________________

Signature: ___________________________

Date: _______ _______ _______
### Allergies and Anaphylaxis

**Medication Administration Form**

#### Student Information
- **Last Name:** [Enter]
- **First Name:** [Enter]
- **Middle Name:** [Enter]
- **Date of Birth:** \__/__/YYYY
- **Sex:**
  - Male
  - Female
- **OSIS Number:** [Enter]
- **Weight:** [Enter]
- **School:** (Include name, number, address and borough)
- **DOE District:** [Enter]
- **Grade:** [Enter]
- **Class:** [Enter]

#### Health Care Practitioners Complete Below

<table>
<thead>
<tr>
<th>Specify Allergy</th>
<th>Specify Allergy</th>
<th>Specify Allergy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy to...</td>
<td>Allergy to...</td>
<td>Allergy to...</td>
</tr>
<tr>
<td>History of asthma?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>History of anaphylaxis?</td>
<td>Yes</td>
<td>Date</td>
</tr>
<tr>
<td>If yes, system affected</td>
<td>Respiratory</td>
<td>Other</td>
</tr>
<tr>
<td>Treatment</td>
<td>Date</td>
<td>Date</td>
</tr>
<tr>
<td>History of allergy testing?</td>
<td>Yes</td>
<td>Date</td>
</tr>
</tbody>
</table>

#### SEVERE REACTION
- **CALL 911, immediately administer:**
  - Epinephrine Auto-Injector 0.15 mg
  - Epinephrine Auto-Injector 0.3 mg (retractable device, preferred) intramuscularly into the anterolateral thigh for the following symptoms:
    - 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 a plant or insect sting or the following food(s):

#### Select In School Medications

<table>
<thead>
<tr>
<th>Student Skill Level</th>
<th>Parent's Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Student: nurse/nurse-trained staff must administer</td>
<td></td>
</tr>
<tr>
<td>Supervised Student: Student self-administers, under adult supervision</td>
<td></td>
</tr>
<tr>
<td>Independent Student: Student is self-carry/self-administer</td>
<td></td>
</tr>
</tbody>
</table>

#### MILD REACTION
- **Give antihistamine:** Name, Preparation/Concentration:
  - Dose:
  - Route:
  - Frequency: Q hours as needed for the following symptoms:
    - Itchy nose, sneezing, itchy mouth
    - A few hives
    - Mild stomach nausea or discomfort
  - Other:
  - If symptoms of severe allergy/anaphylaxis develop, use epinephrine:

#### OTHER MEDICATION
- **Give Name:** Preparations/Concentration:
  - Dose:
  - Route:
  - Frequency:

#### Home Medications (Include over-the-counter)

#### Health Care Practitioner Information
- **Name:**
- **Last Name:** [Enter]
- **First Name:** [Enter]
- **Signature:** [Enter]
- **Date:** \__/__/YYYY
- **Address:** [Enter]
- **NYS License #:** [Enter]
- **NPI #:** [Enter]

**Incomplete Practitioner Information Will Delay Implementation of Medication Orders. Forms Cannot Be Completed by a Resident.**

**Parents Must Sign Page 2 

Rev 3/15**
ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM
Provider Medication Order Form | Office of School Health | School Year 2018–2019
DUE: JULY 15th. Forms submitted after July 15th may delay processing for new school year
PARENTS/GUARDIANS FILL BELOW

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 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 get another medicine for my child to use when he or she is not in school or is on a school trip.
   - 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.
   - 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 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), the Office of School Health (OSH) may provide health services to my child. These services may include 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 a new MAF (whichever is earlier).
   - 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 Student Accommodation Plan. This plan will be completed by the school.
   - 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.
   - If the school nurse is unavailable, I may be notified to come to school to give my child medicine.

SELF-ADMINISTRATION OF MEDICATION:

- 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 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 medicine if my child is temporarily unable to carry and give him or herself medicine.
- 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.

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: [ ]
Print Parent/Guardian’s Name: [ ]
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: [ ]
Contact Telephone Number (_____) ____-______

For Office of School Health (OSH) Use Only

OSIS Number: [ ]
Received by: [ ]
Date __/__/____
Reviewed by: [ ]
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 OSIS contact with prescribing health care practitioner ☐ Modified ☐ Not Modified

*Confidential information should not be sent by email
# Diabetes Medication Administration Form - DMAF

**Provider Medication Order Form - Office of School Health - School Year 2018-2019**

**DUE: JULY 19th.** Forms submitted after July 19th may delay processing for new school year. Please fax all DMAFs to 347-335-8932/8945.

## Student Information
- **Last Name:** [Student Last Name]
- **First Name:** [First Name]
- **Date of Birth:** [Date of birth]
- **GENDER:** 
- **Grade:** [Grade]
- **Class:** [Class]

## Health Care Practitioners Complete Below

### Hypoglycemia
- **Actions:** 
- **Emergency Action Plan:** 
- **Blood Glucose (bg) Monitoring Skill Level:**
- **Insulin Administration Skill Level:**

### Hypoglycemia
- **Use CGM readings but not for insulin dosing:** [ ]
- **Use FDA approved CGM readings for bg monitoring and insulin dosing:** [ ]

### bG Monitoring
- **Glucometer:** 
- **Insulin Type:** 
- **Insulin Sensitivity Factor (ISF):** [ ]
- **Insulin Sensitivity Factor (ISF):** [ ]

### Carbohydrate Coverage
- **Carbohydrate to insulin ratio:** [ ]
- **Correction factor:** [ ]

### Health Care Practitioner Signature
- **Name:** [Health Care Practitioner Name]
- **Title:** [Title]
- **Signature:** [Signature]
- **Date:** [Date]
DIABETES MEDICATION ADMINISTRATION FORM

Provider Medication Order Form—Office of School Health—School Year 2018-2019

DUE: JULY 15th. Forms submitted after JULY 15th may delay processing for new school year. Please fax all DMAs to 517-336-8932/8940.

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

1. I consent to the nurse giving my child's prescribed medicine, and my child's school checking my child's blood sugar, and teaching my child's low blood sugar based on my child's health care practitioner's directions. The school may perform these actions on school grounds or during school trips.
2. I also consent to any equipment needed for my child's medicine being stored and used at school.
3. I understand that:
   • I must give the school nurse my child's medicine, snacks, and equipment. I will try to give the school safety lancets and other safety needle devices and supplies to check my child's blood sugar levels and give insulin.
   • All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
   • Prescription medicine must have the original pharmacy label on the bottle or box. 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 medication, 7) dosage, 8) when to take the medicine, 9) how to handle the medicine, and 10) any other directions.
   • I must immediately tell the school nurse about any change in my child's medicine 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 on this form.
   • By signing this Medication Administration Form (MAF), OSH may provide health services to my child. These services may include 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 a new MAF (whichever is earlier).
   • If this medication order expires, and my child's health care practitioner does not write a new MAF, an OSH health care practitioner may fill out a new MAF for my child. OSH will not need my signature to write future diabetes MAFs.
   • OSH and the Department of Education (DOE) are responsible for making sure that my child can safely test his or her blood sugar in the medical room and any school location.
   • This form represents my request and consent for the diabetes services described on this form. It is not an agreement by OSH to provide the requested services. If OSH declines to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   • 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.
   • If the school nurse is unavailable, I may be notified to come to school to give my child medicine.

FOR SELF-ADMINISTRATION OF MEDICINE:

- I certify 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 all results of my child's use of this medicine in school. The school nurse 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 school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

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: ____________

Print Parent/Guardian's Name: ____________

Date Signed: ____________ Parent/Guardian's Email: ____________

Parent/Guardian's Address:

Telephone Numbers: Daytime: ____________ Home: ____________ Cell Phone: ____________

Alternate Emergency Contact's Name: ____________ Contact Telephone Number: ____________

For Office of School Health Use Only

OSH Number: ____________

Received by: ____________ Date: ____________ Reviewed by: ____________ Date: ____________

Services provided by: [ ] Nurse [ ] PHN [ ] OSH Public Health Advisor (for supervised students only) [ ] School Based Health Center

Signature and Title (PHN or OSH):

Revisions per OSH after consultation with prescribing health care practitioner: [ ] Modified [ ] Not Modified

*Confidential information should not be sent by email.
### DIABETES MEDICATION ADMINISTRATION FORM ADDENDUM

**Provider Medication Order Form – Office of School Health – School Year 2018-2019**

<table>
<thead>
<tr>
<th>Student Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Male</th>
<th>Female</th>
<th>USIS #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**School (Include name, number, address and borough)**

<table>
<thead>
<tr>
<th>Dept</th>
<th>District</th>
<th>Grade</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CONTINUOUS GLUCOSE MONITORING (CGM) ORDERS

- **Check one:**
  - CGM is to be used for monitoring ONLY/FDA approved CGM to be used to replace finger stick blood glucose readings, within the limits of the manufacturer’s protocols.
  - Name and Model of CGM:

  - For dextrostix - finger stick bg will be done when:
    1. Symptoms don’t match the CGM readings.
    2. The student has taken acetaminophen (Tylenol) in the past 8 hours.
    3. There is some reason to doubt the sensor (e.g., sensor doesn’t have both arrow and number)
    4. Readings < 80 mg/dl

  - If CGM needs calibration, test bg.

**This section is only for CGM used for dosing**

- For bg < ___ mg/dl and any ↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓↓→
REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

HEALTHCARE PRACTITIONERS COMPLETE BELOW

-one order per form (make copies of this form for additional orders). Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization.

- Clean Intermittent Catheterization Cath size ___ Fr.
- Central Venous Line
- G-Tube Feeding* □ Bolus □ Pump □ Gravity Cath size ___ Fr.
- J-Tube Feeding* □ Bolus □ Pump □ Gravity Cath size ___ Fr.
- Naso-Gastric Feeding* Cath size ___ Fr.
- Specialized/Non-Standard Feeding Cath size ___ Fr.
- Feeding Tube replacement if dislodged - specify in area below
- Oral / Pharyngeal Suctioning Cath size ___ Fr.

Student will also require treatment: □ during transport □ on school-sponsored trips □ during after-school programs

Student Skill Level (Select the most appropriate option):

- Nurse-Dependent Student: nurse must administer treatment
- Supervised Student: student self-administers under adult supervision
- Independent Student: student self-carry/self-administer

Practitioner's Initials

1. Diagnosis: Enter ICD-10 Codes and Conditions (related to the diagnosis)

2. Treatment required in school:

   - Feeding: Formula Name □ Concentration □ Route □ Amount/Rate □ Duration □ Specific time(s) of administration
     * Please note that parent prepared feeding or nurse prepared feeding, i.e. mixing powder with water, must receive approval from the Director/Designee of Nursing
     - Oxygen administration: □ Amount (L) □ Route □ Frequency/specific time(s) of administration □ Specify Symptoms
     - Other Treatment: Treatment Name □ Route □ Frequency/specific time(s) of administration □ Specify Symptoms
     - Additional instructions or treatment:

3. Conditions under which treatment should not be provided:

4. Possible side effects/adverse reactions to treatment:

5. Specific instructions for nurse (If one is assigned and present) in case of 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 (Please Print)

LAST NAME
FIRST NAME
SIGNATURE

Address
Tel. No. ( ) Fax. No. ( )
E-mail address
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 PARENTS MUST SIGN PAGE 2
Section 504 Accommodations

- Once the Para request is reviewed and recommended by an OSH Physician, the processor then forwards the request to the Nursing Unit, Attention: Sharna Green, Para Support Liaison. Ms. Green will reach out to the agencies to request a Para for NPS and Charter Schools. The agency will then contact the family to set up a meeting with staff that they identify to fill the role of para. The parent will then agree upon meeting to accept the individual who will be the para for their child.

- If after OSH physician review, a para request is denied, the Para Support Liaison will notify the school and/or parent, whomever submitted the request to Central Office.

<table>
<thead>
<tr>
<th>Zainab Samura</th>
<th>347-396-8945</th>
<th><a href="mailto:zsamura@health.nyc.gov">zsamura@health.nyc.gov</a></th>
</tr>
</thead>
</table>

Zainab Samura 347-396-8945 zsamura@health.nyc.gov
Medical Review for 504 Accommodations - to be completed by the Health Care Practitioner - page 1
### Medical Review for 504 Accommodations - to be completed by the Health Care Practitioner - page 2

### Allergy/Anaphylaxis

<table>
<thead>
<tr>
<th>Source of allergy documentation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Anaphylaxis?</td>
</tr>
<tr>
<td>If yes, specify symptoms:</td>
</tr>
<tr>
<td>Medications</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes on Allergy/Anaphylaxis MAF completed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the student have a history of developmental or cognitive delay?</td>
</tr>
<tr>
<td>If yes, specify diagnosis/diagnoses</td>
</tr>
<tr>
<td>Does the student have prior experience with self-monitoring?</td>
</tr>
<tr>
<td>Can the student:</td>
</tr>
<tr>
<td>□ Independently self-monitor and self-manage?</td>
</tr>
<tr>
<td>□ Recognize symptoms of an allergic reaction?</td>
</tr>
<tr>
<td>□ Promptly inform an adult as soon as accidental exposure occurs or symptoms appear, or ask a friend for help?</td>
</tr>
<tr>
<td>□ Follow safety measures established by a parent/guardian and/or school team?</td>
</tr>
<tr>
<td>□ Understand not to trade or share foods with anyone?</td>
</tr>
<tr>
<td>□ Wash hands before and after eating?</td>
</tr>
<tr>
<td>□ Develop a relationship with the school nurse or another trusted adult in the school to assist with the successful management of allergy in the school?</td>
</tr>
<tr>
<td>□ Carry an epinephrine auto-injector?</td>
</tr>
</tbody>
</table>

#### Provider Signature:

### Diabetes

When was the student diagnosed with diabetes?

Are current DMAP orders on file at school for this student?

Does the student have any cognitive challenges or physical disabilities that interfere with the student providing self-care for their diabetes? If yes, please specify:

Can the student identify symptoms of hypoglycemia?

Can the student notify an adult when they feel that their blood glucose is not normal?

What is the plan to transition the student to independent functioning?

#### Provider Signature:

### Seizure Disorder

Type of Seizure

Frequency of Seizures

Medication(s), including emergency medications

Are the seizures well-controlled by the current medication regimen?

Does the student require routine or an emergency medication in school?

If yes, has an MAF been completed?

Other Associated Symptoms, including medication side effects

Number of seizure-related ER visits during the last year

Number of seizure-related hospitalizations/ICU admissions

Frequency of office visits/monthly

Last Office Visit

Activity Restrictions

#### Provider Signature:

### DO NOT WRITE BELOW: SCHOOL USE ONLY

Available School-Specific Allergy Resources |

- Allergy Table(s) in the lunchroom: ______ staff members for supervision
- Allergy Table(s) in the classroom: ______ staff members trained
- General Staff Training for Epinephrine administration: ______ staff members trained
- Student-Specific Training for Epinephrine administration: ______ staff members trained
- Allergy Resources Plan |
| Other |

Name of Principal or Principal's Designee

---

[Medical Review Form Image]
Medical Review for 504 Accommodations - to be completed by the parent/guardian
HIPAA Form

Authorization for Release of Health Information Pursuant to HIPAA

Patient Name: ____________________________ Date of Birth: ____________________________ Social Security Number: ____________________________

Patient Address: ____________________________

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(b), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of the people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 680-2493 or the New York City Commission of Human Rights at (212) 308-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMATION WITH, THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND ITS EMPLOYEES, AGENTS AND CONTRACTORS.

7. Specific information to be released: 
   [ ] Medical Record from (insert date) ____________________________ to (insert date) ____________________________
   [ ] Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consultations, billing records, insurance records, and records sent to you by other health care providers.

   Other: ____________________________
   Include: (Indicate by initialed)
   [ ] Alcohol/Drug Treatment
   [ ] Mental Health Information
   [ ] HIV-Related Information

8. Reason for release of information:
   [ ] At request of individual
   [ ] Other: ____________________________

9. THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS SIGNED BY THE PATIENT OR REPRESENTATIVE UNLESS OTHERWISE SPECIFIED HERE.

10. If not the patient, name of person signing form: ____________________________

11. Authority to sign on behalf of patient: ____________________________

All items on this form have been complete and my questions about his form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law: ____________________________

Date: ____________________________

*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.
Release of students Who Become Ill during the School Day

Elementary and Middle Schools

Students in grades Pre-K-8 who become ill while at school may only be picked up from school by a parent/guardian or other adult designated on the student’s blue, home-contact card.
Release of students Who Become Ill during the School Day

High Schools

If a high school student becomes ill at school, the school must obtain consent from the student’s parent/guardian allowing the student to be released from school to travel home or to a doctor unaccompanied. In addition, a school health professional must agree that the student is not too ill to either walk or travel alone using public transportation. If the student is deemed not well enough to travel alone by the school health professional, s/he may only be picked up by a parent/guardian or other adult designated on the student’s blue, home-contact card.
All schools must keep a written record of a parent’s verbal consent, which should include the name of the staff member(s) who received consent and the name of the school health professional who agreed that the student was well enough to walk or travel alone using public transportation.

For questions, please contact your school’s FSC health director, if applicable.
# Office of School Health

## Public Health Initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description of program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASTHMA</strong></td>
<td>Asthma management programs - Open Airways (6 week program) in grades 3-5. EASI Protocol ICS - Program</td>
</tr>
<tr>
<td><strong>HOP</strong></td>
<td>Health Options &amp; Physical Activity Program - obesity awareness and prevention program (students &gt; 99% BMI)</td>
</tr>
<tr>
<td><strong>STARS</strong></td>
<td>Screening the At Risk Student (High School, Middle School and elementary schools) - a screening program for suicide prevention</td>
</tr>
<tr>
<td><strong>CATCH</strong></td>
<td>Connecting Adolescents to Comprehensive Care (High Schools) - a growing program in selected schools to prevent teenage pregnancy</td>
</tr>
</tbody>
</table>
Head Lice

- Principal will appoint lice designee/s to examine hair of students with potential head lice
- Nurse will train designee/s to identify head lice and is available for case management and patient education for difficult cases is also available for case management and patient education for difficult cases
- Presence of nits does not warrant exclusion from school.
- Refer to the DOE website for latest guidance
Frequently Asked Questions (FAQs)

- My state authorizer is requiring me to have a nurse but I don’t qualify, what should I do?
- What should I do if I have a student that needs a trip nurse and the Office of School Health cannot assign one?
- We have a trip today can I ask the nurse to hand over the medications so I can take them on the trip and administer to the students?
FAQs cont’d

► What should I do if I have a student that needs a trip nurse and the Office of School Health cannot assign one?

► One of my parents wants to train me to administer a rectal seizure medication. Can I get trained?

► If a student has a headache can I give them Aspirin?
FAQs cont’d

► Can I retain student medications in the principal’s office and have school staff administer medication to students during the school day?

► Can I insist on being present while a student is being evaluated by a school nurse?

► Can I treat sick children myself (e.g. administer an asthma inhaler) rather than bring the child to the nurse for evaluation and treatment?
FAQs cont’d

- Can I relay the treatment/care provide by the school nurse to the parent and request the school nurse not call parents directly?
- What is the Medication Administration Form process? How is it reviewed?
- What is the 504 form process and how is it reviewed?
- Do I need to give the school nurse all the medical forms I’ve received? The CH 205 and MAFs?
SUMMARY

► It is vital for School Health staff to have effective working relationships with principals

► We need to balance the school support public health and the provision of clinical services

► Many of our responsibilities are determined by State law, NYC health code and Chancellor’s regulations
Who to call with nursing concerns?

- Please email and/or call the respective borough nursing director with questions or concerns as it relates to the school nurse. The directory of borough nursing directors can be found on the DOE Website:

http://schools.nyc.gov/StudentSupport/NonAcademicSupport/Health/Forms/DirNurseDir.htm
Who to call with physician concerns? . .

Please email and/or call the respective supervising physician with questions or concerns as it relates to the school physician. The directory of supervising physicians can be found on the DOE website:

School Health

For more information:
http://schools.nyc.gov/Offices/Health
Looking forward to working with you all to have a productive, successful, safe, health, and happy school year!

Thank you!