# REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment Order Form | Office of School Health | School Year 2021–2022

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

### Student Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
<th>Date of Birth M M / D D / Y Y Y Y</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
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### OSIS Number

<table>
<thead>
<tr>
<th>OSIS Number</th>
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<tbody>
<tr>
<td>__ __ __ __ __ __ __ __ __</td>
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</table>

### School Information

<table>
<thead>
<tr>
<th>School (include ATSDBN/name, address and borough)</th>
<th>DOE District</th>
<th>Grade</th>
<th>Class</th>
</tr>
</thead>
<tbody>
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### 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.

**Student will also require treatment:**

- during transport
- on school-sponsored trips
- during afterschool programs

### Student Skill Level

**Select the most appropriate option:**

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

**Practitioner's initials**

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

### Healthcare Practitioners

<table>
<thead>
<tr>
<th>Health Care Practitioner</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please Print and circle one: MD, DO, NP, PA)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Tel. No. ( __ __ ) __ __ __ __ __ __</th>
<th>Fax. No ( __ __ ) __ __ __ __ __ __</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>E-mail address</th>
<th>Cell phone ( __ __ ) __ __ __ __ __ __</th>
<th>Date __ __ / __ __ / __ __ __ __</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NYS License No (Required)</th>
<th>NPI No.</th>
<th>Date __ __ / __ __ / __ __ __ __</th>
</tr>
</thead>
</table>

**INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS**

**FORMS CANNOT BE COMPLETED BY A RESIDENT**

**Rev 4/21**

**PARENTS MUST SIGN PAGE 2**
REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)
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Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

PARENT/GUARDIAN READ, COMPLETE, AND SIGN: BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child’s medical supplies, equipment and prescribed treatments being stored and given at school based on directions from my child’s health care practitioner.

2. I understand that:
   - I must give the school nurse my child’s medical supplies, equipment and treatments.
   - All supplies I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired supplies for my child’s use during school days.
     - Supplies, equipment and treatments should be labeled with my child’s name and date of birth.
   - I must immediately tell the school nurse about any change in my child’s treatments or the health care practitioner’s instructions.
   - The Office of School Health (OSH) and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this form, I authorize OSH to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The treatment instructions/orders on this form expire at the end of my child’s school year, which may include the summer session, or when I give the school nurse a new form (whichever is earlier). When this medication order expires, I will give my child’s school nurse a new MAF written by my child’s health care practitioner. OSH will not need my signature for future MAFs.
   - This form represents my consent and request for the medical services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child’s medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

FOR SELF-TREATMENT (INDEPENDENT STUDENTS ONLY)
   - I certify/confirm that my child has been fully trained and can perform treatments on his or her own. I consent to my child carrying, storing and giving him or herself the treatments prescribed on this form in school. I am responsible for giving my child these supplies and equipment labeled as described above. I am also responsible for monitoring my child's treatments, and for all results of my child’s self-treatment in school. The school nurse will confirm my child’s ability to perform treatments on his/her own. I also agree to give the school clearly labeled “back up” equipment or supplies in the event that my child is unable to self-treat.

Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child’s primary medical provider.

FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

Student Last Name First Name MI Date of birth ___ / ___ / ___ ___ School

School ATSDBN/Name

Borough District

Parent/Guardian’s Name (Print)

Parent/Guardian’s Signature Date Signed ___ / ___ / ___ ___

Parent/Guardian’s Email

Parent/Guardian’s Address

Telephone Numbers:

Daytime ( ___ ___ ) ___ ___ - ___ ___ Home ( ___ ___ ) ___ ___ - ___ ___ Cell Phone* ( ___ ___ ) ___ ___ - ___ ___

Alternate Emergency Contact’s Name Relationship to Student Alternate Contact’s Telephone Number ( ___ ___ ) ___ ___ - ___ ___

FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

OSIS Number:

Received by: Name Date ___ / ___ / ___ ___ Reviewed by: Name Date ___ / ___ / ___ ___

☐ 504 ☐ IEP ☐ Other Referred to School 504 Coordinator: ☐ Yes ☐ No

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor (For supervised students only) ☐ School Based Health Center

Signature and Title (RN OR SMD): Date School Notified & Form Sent to DOE Liaison ___ / ___ / ___ ___

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

*Confidential information should not be sent by e-mail.