B student	Provider Treatment Ord	F MEDICALLY PRESC er Form Office of School He rms submitted after June 1 st m	alth School Year 202	21–2022	DICATION)		
Student Last Name	First Name	Middle	Date of birth/		□ Male □ Female		
OSIS Number			MM	DD YYYY			
OSIS Number School (include ATSDBN/name, a			DOE District	Grade	Class		
School (include ATSDBN/hame, a	iduless and bolough)		DOE DIStrict	Glade	Class		
	M (make copies of thi	RE PRACTITIONERS CO s from for additional orders and medical authorization.		on(s) / additional	sheet(s) if		
 Central Line Dressing Change Feeding: Cath SizeFr. Nasogastric □ G-Tube □ J-T 	Chest Clapping/Percussion Feeding Tube replacement if dislodged - specify in #5 Trach Replacement - specify in #5 Clean Intermittent Catheterization: Cath SizeFr. Oral / Pharyngeal Suctioning: Cath SizeFr Trach Replacement - specify in #5 Central Line Ostomy Care Vagus Nerve Stimulator Dressing Change Oxygen Administration - specify in #2 Other: Feeding: Cath SizeFr. Postural Drainage Other: Pulse Oximetry monitoring Pulse Oximetry monitoring Trach Care : Trach. Size						
·		Level (Select the most ap					
	urse must administer trea self-treats under adult su ti s self-carry/self-treat (<i>in</i>	tment pervision		ctively during schoo	ol, field trips, and		
Practitioner's initials				,	<u>,</u>		
1. Diagnosis : Diagnosis is self- limited]Yes □ No	Enter ICD-10	Codes and Conditions		<u>DIAGNOSIS)</u>		
2. Treatment required in sch Feeding: Formula N * Premixing of medications and for feedings for administration via G Flush with mL Oxygen administration: Ar Other Treatment:	lame Conce eedings by parents is no -tube as ordered by the c before feeding 	hild's primary medical provide	to administer. Nurses r.		hix medications and		
Additional Instructions of the second s	Treatment Name or Treatment:	Route Frequency	/specific time(s) of admir	histration Specify	y signs & symptoms		
3. Conditions under which trea	tment should not be pro	vided:					
4. Possible side effects/adverse reactions to treatment:							
 Emergency Treatment: Provide specific instructions for nurse (if one is assigned and present) in case of emergency, including adverse reactions, including dislodgement or blockage of tracheostomy or feeding tube: 							
6. Specific instructions for non-	medical school personn	el in case of adverse reaction	s, including dislodgen	nent of tracheosto	my or feeding tube:		
7. Date(s) when treatment show	uld be: Initiated/	/ Terminate	ed / / /				
Health Care Practitioner LAST (Please Print and circle one: MD, DO,		FIRST NAME	Signature	e			
Address		Tel. No. ()_					
E-mail address)				
NYS License No (Required) NPI No. Date / /							

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)

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

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

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

FOR SELF-TREATMENT (INDEPENDENT STUDENTS ONLY)

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

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

Student Last Name	First Name	MI	Date of birth / / /	School			
School ATSDBN/Name			Borough	District			
Parent/Guardian's Name (Print)		Parent/Guardian's Signature		Date Signed			
Parent/Guardian's Email			Parent/Guardian's Address				
Telephone Numbers: Daytime()	Home(_)_	Cell Ph	one* ()			
Alternate Emergency Contact's Name	Relationship to Student	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 Se	chool 504 Coordinator: Ves 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			