

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

OFFICE OF SCHOOL HEALTH - School Year 2016-2017

ATTACH STUDENT PHOTO HERE	Student Last Name	First Name	Middle	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	
				___/___/____ MM DD YYYY		
	Guardian e-mail address*			OSIS Number _____		
School (include name, number, address and borough)				DOE District	Grade	Class
				____	____	____

Health Care Practitioner's Statement/Order

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).

- | | | |
|---|--|--|
| <input type="checkbox"/> Clean Intermittent Catheterization Cath. Size _____ | <input type="checkbox"/> Tracheostomy Care Trach. Size _____ | <input type="checkbox"/> Ostomy Care |
| <input type="checkbox"/> Central Venous Line | <input type="checkbox"/> Trach. suctioning Cath. Size _____ | <input type="checkbox"/> Chest Clapping |
| <input type="checkbox"/> Gastrostomy/Jejunostomy Feeding: <input type="checkbox"/> Bolus <input type="checkbox"/> Pump <input type="checkbox"/> Gravity | <input type="checkbox"/> Trach replacement - specify in area below | <input type="checkbox"/> Percussion |
| <input type="checkbox"/> FeedingTube replacement if dislodged - specify in area below | <input type="checkbox"/> Oxygen Administration | <input type="checkbox"/> Postural Drainage |
| <input type="checkbox"/> Naso-Gastric Feeding | <input type="checkbox"/> Pulse Oximetry monitoring | <input type="checkbox"/> Dressing Change |
| <input type="checkbox"/> Specialized/Non-Standard Feeding | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Oral / Pharyngeal Suctioning | | |

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

Select the most appropriate option for this student:

- Nurse-Dependent Student: nurse must administer treatment
- Independent Student: student is self-carry/self-administer (**NOT ALLOWED FOR CONTROLLED SUBSTANCES**): PARENT MUST INITIAL REVERSE SIDE
- I attest student demonstrated the ability to self-administer the prescribed treatment effectively for school/field trips/school-sponsored events _____
- Practitioner's initials

1. Diagnosis Enter ICD Codes and Conditions (RELATED TO THE DIAGNOSIS)

_____ _____

Diagnosis is self-limited Yes No

2. Treatment required in school:

Feeding: _____

Formula Name	Concentration	Route	Amount/Rate	Duration	Frequency/specific time(s) of administration
--------------	---------------	-------	-------------	----------	--

Oxygen administration: _____ _____ prn O2 Sat < _____%

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 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 LAST NAME	FIRST NAME (Please Print)	Signature
Address	Tel. No. (____)____-____	Fax. No (____)____-____
E-mail address*		Cell phone* (____)____-____
NYS License No (Required) _____	Medicaid No _____	NPI No _____
		Date ___/___/_____

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

OFFICE OF SCHOOL HEALTH - School Year 2016-2017

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF ORDERS

PARENT/GUARDIAN'S CONSENT

I hereby consent to the provision of medically prescribed treatment in accordance with the attached instructions of my child's health care practitioner. I understand that it is my responsibility to furnish all necessary equipment and supplies for the provision of the requested treatment, and that I must immediately advise the school nurse of any change in the prescription or instructions stated above.

I understand that this consent is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction program session; or such time that I deliver to the school nurse a new prescription or instructions issued by my child's health care practitioner regarding the administration of the above-prescribed monitoring and treatment (whichever is earlier).

By submitting this Request for Provision of Medically Prescribed Treatment (Non-Medication) Form, I am requesting that my child be provided with specific health services by the Department and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH). Full and complete instructions regarding the provision of the above-requested health service(s) are included in this form. I understand that the Department, DOHMH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form.

I recognize that this form is not an agreement by the Department or DOHMH to provide the services requested, but, rather, my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I understand that the Department or DOHMH, and their employees and agents, may contact, consult, and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care practitioner and/or pharmacist that has provided medical or health services to my child.

****SELF-ADMINISTRATION OF TREATMENT: Initial this paragraph for prescribed treatments self-administered by the student**

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed treatment. I further consent to my child's self-administration of the above-prescribed treatment in school. I acknowledge that I am responsible for providing my child with such equipment in containers labeled as described above, for any and all monitoring of my child's use of such treatment, for any and all consequences of my child's self-treatment in school. I understand that the school nurse will confirm my child's ability to self-treat in a responsible manner. In addition, I agree to provide "back-up" equipment in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

_____ I consent to the school nurse storing equipment and/or administering treatment to my child in the event that my child is temporarily incapable of self-storage and/or self-treatment.

Parent/Guardian's Signature	Print Parent/Guardian's Name
Date Signed ___/___/_____	Parent/Guardian's Address
Telephone Numbers: Daytime (____) _____ - _____ Home (____) _____ - _____ Cell Phone* (____) _____ - _____	
Alternate Emergency Contact's Name	Alternate Contact's Telephone Number (____) _____ - _____

DO NOT WRITE BELOW – FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

Student Last Name	First Name	MI	OSIS No: _____
Received by: Name	Date ___/___/_____	Reviewed by: Name	Date ___/___/_____
<input type="checkbox"/> 504 <input type="checkbox"/> IEP <input type="checkbox"/> Other	Referred to School 504 Coordinator: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Services provided by: <input type="checkbox"/> Nurse <input type="checkbox"/> OSH Public Health Advisor <input type="checkbox"/> School Based Health Center			
Self-Directs Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Signature and Title (RN OR SMD):		Date School Notified & Form Sent to DOE Liaison ___/___/_____	

FOR Office of School Health (OSH) USE: Revisions as per OSH contact with prescribing health care practitioner.