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** __/__/____ MM DD YYYY	☐ Male ☐ Female
	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 from for additional orders)
(Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization).

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

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: _____ _____ ☐_____ ☐ prn_____
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 __/__/____

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

Rev 4/16

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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 prevision 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 __ __ / __ __ / __ __ __ __
☐ **504** ☐ **IEP** ☐ **Other**	**Referred to School 504 Coordinator**: ☐ Yes ☐ No
Services provided by: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center	
Self-Directs Treatment: ☐ Yes ☐ 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.	

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