Mete foto elèv la la a

MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION) FORM

Fòm preskripsyon doktè pou bay tretman | Biwo sante lekòl | Ane lekòl 2024-2025

Tanpri voye l tounen ba enfimyè/Sant sante ki nan lekòl la. Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la.

Siyati elèv la:______________________ Non:______________________ 2yèm non: __________ Dat nesans: ______________

Sèks: ☐ Gason ☐ Fi Nimewo OSIS: ______________ Nivo klas: __________ Klas: ______________

Lekòl (mete ATSDBN non, nimewo, adrès ak borough): ______________________________ Distri DOE: ____________

SE YON DOKTÈ KI POU RANPLI PI BA A / HEALTH CARE PRACTITIONERS COMPLETE BELOW

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.

☐ Blood Pressure Monitoring
☐ Chest Clapping/Percussion
☐ Clean Intermittent Catheterization: Cath Size _____ Fr.
☐ Central Line/PICC Line
☐ Dressing Change
☐ Feeding: Cath Size _____ Fr.
 ☐ Nasogastric ☐ G-Tube ☐ J-Tube
 ☐ Bolus ☐ Pump ☐ Gravity
 ☐ Spec./Non-Standard*

☐ Feeding Tube replacement if dislodged - specify in #5
☐ Oral / Pharyngeal Suctioning: Cath Size _____ Fr.
☐ Ostomy Care
☐ Oxygen Administration - specify in #1
☐ Postural Drainage
☐ Pulse Oximetry monitoring

☐ Trach Care: Trach. Size _______
☐ Trach Replacement - specify in #5
☐ Trach suctioning: Cath Size _____ Fr
☐ Other: ______________________

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
 ☐ I attest student demonstrated ability to self-administer the prescribed treatment effectively during school, field trips, and school sponsored events. Practitioner's Initials: _________

Diagnosis: ______________________________
Diagnosis is self- limited: ☐ Yes ☐ No

Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS)
☐ _____._____ ☐ _____._____ ☐ _____._____

1. Treatment required in school:

☐ **Feeding**: Formula Name: ______________________________ Concentration: ______________
 Route: ______________ Amount/Rate: Duration: __________ Frequency/specific time(s) of administration: ______________
 ***Per the New York State Education Department, nurses are not permitted to administer premixed medications and feedings. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.**

☐ **Flush** with ______________________ mL __________ ☐ Before feeding ☐ After feeding

☐ **Oxygen Administration:** Amount (L): __________ Route: __________ Frequency/specific time(s) of administration: ______________
 ☐ prn ☐ O2 Sat < _______ % Specify signs & symptoms:

☐ **Other Treatment:** Treatment Name: ______________ Route: __________ Frequency/specific time(s) of administration: ______________
 Specify signs & symptoms:

☐ **Additional Instructions or Treatment:**

2. Conditions under which treatment should not be provided:

3. Possible side effects/adverse reactions to treatment:

4. Emergency Treatment: Provide specific instructions for clinical personnel (if present) in case of emergency or adverse reactions, including dislodgement or blockage of tracheostomy or feeding tube:

5. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:

6. Date(s) when treatment should be: Initiated: ______________________ Terminated: ______________________

Health Care Practitioner

Last Name (Print): ______________________ First Name (Print): ______________ **Please check one:** ☐ MD ☐ DO ☐ NP ☐ PA

Signature: ______________________ Date: ______________ NYS License # (Required): ______________ NPI #: ____________

Address: ______________________________________ Email address: ______________________

Telephone: ______________________ FAX: ______________________ Cell Phone: ______________________

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS Rev 3/24

FORMS CANNOT BE COMPLETED BY A RESIDENT / YON REZIDAN DOKTÈ PA KA SIYEN FÒM LAN **PARAN DWE SIYEN PAJ 2 / PARENTS MUST SIGN PAGE 2 ➔**

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Tanpri voye l tounen ba enfimyè/Sant sante ki nan lekòl la. Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la.

PARAN/RESPONSAB LI, RANPLI AK SIYEN: LÈ M SIYEN PI BA A, MWEN DAKÒ AVÈK BAGAY SA YO:

1. Mwen dakò pou yo konsève medikaman pitit mwen ak ba li yo nan lekòl la dapre eksplikasyon doktè/founisè swen sante pitit mwen an bay.
2. Mwen konprann ke:

- Mwen dwe bay enfimyè/founisè Sant sante ki nan lekòl la (SBHC) materyèl, ekipman medikalk ak tretman pitit mwen an.
- **Tout materyèl mwen bay lekòl la fèt pou nèf, kachte nan bwat oswa boutèt orijinal la. M ap bay lekòl la ekipman ki resan, ki pa ekspire pou pitit mwen itilize pandan jounen lekòl la.**
    - Materyèl, ekipman ak tretman yo dwe make ak non, dat nesans pitit mwen an sou yo.
- Mwen dwe **imedyatman** di enfimyè lekòl la/founisè SBHC a nenpòt chanjman ki genyen nan tretman pitit mwen an oswa nan eksplikasyon doktè k ap trete l.
- Biwo sante nan lekòl (Office of School Health, OSH) ak ajan li ki patisipe nan ofri pitit mwen an sèvis sante ki pi wo yo konte sou presizyon ki nan enfòmasyon ki sou fòm sa a.
- Lè m siyen fòm sa a, mwen otorize OSH pou bay pitit mwen an sèvis sante. Sèvis sa yo ka genyen ladan pami lòt, yon evalyasyon klinik oswa yon konsiltasyon medikal yon doktè oswa yon enfimyè OSH fè.
- Lòd/eksplikasyon pou bay tretman ki sou fòm sa a ekspire nan fen ane lekòl pitit mwen an, ki ka gen ladan tou sesyon ete, oswa lè mwen bay enfimyè lekòl la yon nouvo fòm MAF(kèlkeswa sa ki rive avan an). Lè preskripsyon medikaman sa a ekspire, m ap bay enfimyè/founisè SBHC lekòl pitit mwen an yon nouvo fòm MAF ke doktè pitit mwen an ap ekri.
- Fòm sa a reprezante konsantman m ak demand mwen fè pou sèvis medikal yo dekri sou fòm sa a. Se pa yon akò OSH genyen pou li bay sèvis ou mande a. Si OSH deside bay sèvis sa yo, pitit mwen an bezwen tou yon Plan akomodasyon Seksyon 504. Se lekòl la k ap ranpli plan sa a.
- Nan objektif pou bay pitit mwen an swen oswa tretman, OSH ka gen nenpòt lòt enfòmasyon yo panse ki nesesè sou pwoblèm medikal pitit mwen an, medikaman l ap pran oswa tretman l suiv. OSH ka pran enfòmasyon sa a nan men nenpòt doktè, enfimyè oswa famasyen ki bay pitit mwen an sèvis.

Dapre Depatman Edikasyon Eta Nouyòk, enfimyè yo pa gen pèmisyon pou yo bay medikaman ak alimantasyon ki deja melanje. Enfimyè ka prepare ak melanje medikaman ak manje pou yo bay nan G-tube jan doktè fanmi an rekòmande l la.

POU ELÈV KI KA PRAN MEDIKAMN POUKONT YO (ELÈV KI ENDEPANDAN SÈLMAN)

- Mwen sètifye/konfime pitit mwen an resevwa bon jan trening epi li kapab fè tretman yo poukont li. Mwen dakò pou pitit mwen an pote, konsève ak fè poukont li tretman yo preskri nan fòm sa a nan lekòl la ak nan pwomnad. Mwen gen responsablite pou bay pitit mwen an materyèl ak ekipman sa yo ak etikèt, jan yo dekri sa pi wo a. Mwen gen responsablite tou pou m sipèvize tretman pitit mwen an ak pou tout konsekans ki genyen nan bay tèt li tretman poukont li. Enfimyè lekòl la/founisè SBHC a pral konfime kapasite pitit mwen an pou l fè tretman poukont li. Mwen dakò tou pou bay lekòl la ekipman oswa materyèl "an rezèv" ki make byen klè sizoka pitit mwen an pa ka bay tèt li tretman poukont li.

Siyati elèv la:________________________ **Non:**___________________ **Inisyal dezyèm non:**_____ **Dat nesans:** ___________________________

Non/ATSDBN lekòl la: ____ Borough: ______________ Distri: _________

Imèl paran/responsab la: _________________________ **Adrès paran/responsab:** ____

Nimewo telefòn: Lajounen: __________________________ **Kay:** ____________________________ **Sèlilè:***: _____________________________

Non paran/responsab: ____ **Siyati paran/responsab** ______________________________

Lòt non moun nou ka kontakte lè gen ijans:

Non: ___________________________________Lyen avèk elèv la: ______________________________Nimewo pou kontakte w: ________________

Pati sa se pou biwo sante nan lekòl (OSH) sèlman / For Office of School Health (OSH) Use Only

OSIS #: _________________________

Received by – Name: _________________________ Date: ____________ Reviewed by – Name: _____________________ Date: ____________

☐ 504 ☐ IEP ☐ Other: ______________________ Referred to School 504 Counselor: ☐ 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 per OSH contact with prescribing health care practitioner: ☐ Clarified ☐ Modified

*Confidential information should not be sent by email / Ou pa dwe voye enfòmasyon konfidansyèl nan yon imèl.

Se pou enprimri sèlman / For print use only