Yeshiva Derech HaTorah

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July 2023

Dear Parents/All Elementary Grades,

We hope this letter finds you and your family doing well and enjoying a relaxing summer.

The safety, health, and welfare of our students, your children, is our primary mission. To that end, we strictly enforce NYC and NYS Departments of Health and Education requirements.

- The ***"Child and Adolescent Health Form"*** is attached in this email and should be submitted to YDH by Monday, August 21, 2023. This form is a health record for your child which the schools are mandated by the NYC and NYS Departments of Health and Education to keep on file as a prerequisite for his admission. As it may require a physical exam, please give it to your child's pediatrician as soon as you receive it, so that it can be completed on time!
  Please have your child's pediatrician complete the attached ***Child and Adolescent Health Form*** for all Grades 1 - 8 students in your family by Monday, August 21, 2023.

- ***2023 / 2024 School Year Immunization Requirements Form***

- For Medical Exemptions, use the attached ***"Medical Request for Immunization Exemption"*** form. ***(Religious exemptions are not accepted in New York State!)***

- Forms that are relevant specifically to your child, (e.g. diabetes, allergies, and the administration in school of other medications), please have your health care provider complete the attached ***"Allergies / Anaphylaxis / Medication Administration" form.***

We are truly grateful for your understanding and anticipate your cooperation and timely response. Your efforts are ***not*** taken for granted! Thank you!

Best wishes,

Rabbi E. Chanales, Head of School Mr. Y. Goldstein, General Studies Principal

NYC | Department of Health and Mental Hygiene | Department of Education

Cheryl Lawrence, MD, FAAP
Medical Director

Office of School Health
30-30 47th Avenue,
Long Island City, NY
11101

June 2023

Dear Parent or Guardian,

New York City has updated the school immunization requirements for the 2023-2024 school year. A list of the vaccine requirements for 2023-2024 is included with this letter. Vaccines protect children from getting and spreading diseases; they are required to attend school.

Before the school year begins, you must submit proof of immunization or blood test results that show immunity (see below) for your child if they are attending childcare or school. **All students in childcare through grade 12** must meet the requirements for:

- The DTaP (diphtheria-tetanus-pertussis), poliovirus, MMR (measles-mumps-rubella), varicella and hepatitis B vaccines.

Children under age 5 who are enrolled in childcare and pre-kindergarten (pre-K) must also meet the requirements for:

- The Hib (*Haemophilus influenza* type b) and PCV (pneumococcal conjugate) vaccines.
- The influenza (flu) vaccine: children must receive the flu vaccine by December 31, 2023 (preferably, when it becomes available in early fall).

Children in grades 6 through 12 must also meet the requirements for:

- The Tdap (tetanus-diphtheria-pertussis) booster and MenACWY (meningococcal conjugate) vaccines.

Blood tests that show immunity to measles, mumps, rubella, varicella, or hepatitis B also meet the requirements (polio labs only if done before September 2019).

Please take the time this summer to review your child's immunization history with your child's healthcare provider. Their provider can tell you whether additional doses of one or more vaccines are required for your child to attend childcare or school this year. **Please note**: If your child received doses of vaccine BEFORE the minimum age (too early), those doses do NOT count toward the number of doses needed.

If you have questions about these 2023-2024 requirements, please contact your childcare center or school's administrative office.

Sincerely,

Cheryl Lawrence

Cheryl Lawrence, MD, FAAP
Medical Director
Office of School Health

Is Your Child Ready for Child Care or School?

2023-2024 School Year

Learn about required vaccinations in New York City.

All students ages 2 months up to 18 years in New York City must get the following vaccinations to go to childcare or school. Review your child's vaccine needs based on their grade level this school year. The number of vaccine doses your child needs may vary based on age and previous vaccine doses received. Your child may need additional vaccines or vaccine doses if they have certain health conditions or if previous doses were given too early. Blood tests that show immunity to measles, mumps, rubella, varicella, or hepatitis B also meet the requirements (polio immunity is only acceptable if the lab test was done before September 2019).

VACCINATIONS	CHILD CARE, HEAD START, NURSERY, 3K OR PRE-KINDERGARTEN	KINDERGARTEN - Grade 5	GRADES 6 -11	GRADE12
Diphtheria , tetanus, and pertussis (DTaP)	**4 doses**	**5 doses** **or 4 doses** ONLY if the fourth dose was received at age 4 years or older **or 3 doses** ONLY if the child is age 7 years or older and the series was started at age 1 year or older	**3 doses**	
Tetanus, diphtheria and pertussis booster (Tdap)			**1 dose** is required at 11 years or older when entering grades 6 - 12 (in compliance until age 11 years)	
Polio (IPV or OPV)	**3 doses**	**4 doses** **or 3 doses** if the third dose was received at age 4 years or older		
Measles, mumps and rubella (MMR)	**1 dose**	**2 doses**		
Hepatitis B	**3 doses**	**3 doses**	**3 doses** **or 2 doses of adult hepatitis B vaccine** (Recombivax HB®) if the doses at least 4 months apart between ages of 11 through 15 years	
Varicella (chickenpox)	**1 dose**	**2 doses**		
Meningococcal conjugate (MenACWY)			**Grade 6: Not applicable** **Grades 7-11: 1 dose**	**Grade 12: 2 doses** **or 1 dose** if the first dose was received at age 16 years or older
***Haemophilus influenzae* type b conjugate (Hib)**	**1 to 4 doses** Depends on child's age and doses previously received			
Pneumococcal conjugate (PCV)	**1 to 4 doses** Depends on child's age and doses previously received			
Influenza	**1 dose**			

Talk to your health care provider if you have questions.

For more information call **311** or visit **nyc.gov/health** and search for **student vaccines.**

NYC | Department of Health & Mental Hygiene | Department of Education

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | **First Name** | **Middle Name** | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | **State** | **Zip Code** | **School/Center/Camp Name** | **District** __ __ **Number** __ __ __

Phone Numbers Home _____ Cell _____ Work _____

Health insurance (including Medicaid)? ☐ Yes ☐ No

☐ **Parent/Guardian** ☐ **Foster Parent** **Last Name** **First Name** **Email**

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***

☐ None ☐ Yes *(list below)*

_____
_____
_____
_____

PHYSICAL EXAM **Date of Exam:** ___ /___ /___

Height _____ **cm** (___ ___ %ile)

Weight _____ **kg** (___ ___ %ile)

BMI _____ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No

Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right _____ /_____ Left _____ /_____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Tdap	___/___/___	___/___/___	___/___/___						
MMR	___/___/___	___/___/___	___/___/___						
Varicella	___/___/___	___/___/___	___/___/___						
Mening ACWY	___/___/___	___/___/___	___/___/___						
Hep A	___/___/___	___/___/___	___/___/___						
Rotavirus	___/___/___	___/___/___	___/___/___						
Mening B	___/___/___	___/___/___	___/___/___						
Other _____	___/___/___	_____	___/___/___						

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

_____ _____
_____ _____
_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __ __/__ __/__ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY **PRACTITIONER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

FORM ID#

MEDICAL REQUEST FOR IMMUNIZATION EXEMPTION

Student Information	DOE Sites	Non-DOE Sites: Facility Information
Student Name:	OSIS #	Facility Name:
Date of Birth __ __/__ __/__ __ __ __ Student Address:	ATS DBN	Contact name/title: Phone: FAX: Address:

Instructions for the Requesting Physician

This form must be completed and signed by a **physician** licensed in New York State and be based on Advisory Committee on Immunization Practices' guidelines, in accordance with NYS Public Health Law Section 2164. Medical exemptions are granted for no more than one year and requests must be resubmitted annually. NYC Department of Health physicians review all medical exemption requests and may request additional information. Parental concerns will not be considered without medical documentation.

The following are NOT valid contraindications to ANY routine vaccine:

- Egg allergy, even if anaphylactic, is not a valid contraindication to MMR, influenza, or any other vaccine.
- Autism and/or developmental delay in the child or family member.
- Mild, acute illness (e.g. low-grade fever, cold, upper respiratory illness, diarrhea, otitis media).
- Contact with immunosuppressed persons by a healthy individual.
- Pregnancy in the household or contact with a pregnant woman.
- Non-severe, life-threatening allergic reaction to vaccination or history of allergies in a relative.
- Prior influenza A and/or B infection (influenza vaccine still required).
- Controlled seizures (with or without medication) or a history of seizures in a relative.

Medical Exemption Request

As the student's physician, I request a medical exemption for (**student name**) _____ **date of birth** _ _/_ _/ _ _ _ _ for the following required immunization(s). I certify under penalty of violation of NYS Public Health Law Section 2164 that the particular immunization(s) will be detrimental to the child's health:

	For children up to the 5th birthday
☐ Hepatitis B ☐ DTaP ☐ Tdap ☐ Td ☐ Polio ☐ MMR ☐ Varicella ☐ MenACWY	☐ PCV13 ☐ Hib ☐ Influenza

Explanation for exemption request for each vaccine(s). Specify diagnosis and/or treatment precluding vaccination, date of event(s), and expected duration of contraindication. Please include supporting documentation. Attach additional pages if needed.

_____
_____
_____
_____
_____
_____

Physician Name:	**NYS License # NY** __ __ __ __ __ __	
Physician Signature:	**Degree (☐MD ☐DO)**	**Date**__ __ / __ __ / __ __ __ __
Office Phone (__ __ __) __ __ __ - __ __ __ __ Ext __ __ __ __ **Cell Phone** (__ __ __) __ __ __ - __ __ __ __		**Stamp**

Parent/Guardian Consent for Release of Information

I, (**parent/guardian name**)_____ authorize (**physician name**) _____ to provide the New York City Departments of Health and Education with information contained in my child's medical record, including, but not limited to laboratory or other records supporting this request.

Parent/Guardian's signature _____**Date** __ __ / __ __ / __ __ __ __

Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

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

Student Last Name	First Name	Middle	**Date of birth** __ __/__ __/__ __ __ __ M M D D Y Y Y Y	○ Male ○ Female
OSIS Number __ __ __ __ __ __ __ __ __	**Weight** _____ kg			
School (include ATSDBN/name, number, address and borough)			**DOE District** __ __	**Grade** / **Class**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	**Specify Allergy**	**Specify Allergy**
☐ Allergy to	☐ Allergy to	☐ Allergy to

History of asthma?	☐ Yes (***If yes, student has an increased risk for a severe reaction)***	☐ No	**Does this student have the ability to:**		
History of anaphylaxis?	☐ Yes Date __ __/__ __/__ __ __ __	☐ No	Self-Manage *(See 'Student Skill Level' below)*	☐ Yes	☐ No
If yes, system affected	☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic		Recognize signs of allergic reactions	☐ Yes	☐ No
Treatment	Date __ __/__ __/__ __ __ __		Recognize/avoid allergens independently	☐ Yes	☐ No

Select In School Medications

1. SEVERE REACTION

A. **Immediately administer epinephrine ordered below, then call 911.**

☐ 0.15 mg
☐ 0.3 mg

Give intramuscularly in the anterolateral thigh for **any** of the following symptoms *(retractable devices preferred)* :

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms
- Feeling of doom, confusion, altered consciousness or agitation

☐ Other:_____

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____
Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

B. If no improvement, or if symptoms recur, repeat in _____ minutes for maximum of _____ times (not to exceed a total of 3 doses)

C. Give antihistamine after epinephrine administration (*order antihistamine below*)

Student Skill Level *(select the most appropriate option)*
☐ Nurse-Dependent Student: nurse/nurse-trained staff must administer
☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

2. MILD REACTION

A. Give antihistamine: Name:_____Preparation/Concentration:_____ Dose:_____ Route: _____
Frequency: ☐ **Q4** hours **or** ☐ **Q6** hours as needed for **any** of the following symptoms:

- Itchy nose, sneezing, itchy mouth
- A few hives or mildly itchy skin
- Mild stomach nausea or discomfort
- Other: _____

B. If symptoms of severe allergy/anaphylaxis develop, or if more than one symptom from each system is present, use epinephrine and call 911.

Student Skill Level *(select the most appropriate option)*
☐ Nurse Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

3. OTHER MEDICATION

- Give Name:_____Preparation/Concentration:_____ Dose: _____
  Route:_____ Frequency: Q_____ ☐ minutes ☐ hours as needed

Specify signs, symptoms, or situations:_____
If no improvement, indicate instructions:_____
Conditions under which medication should not be given: _____

Student Skill Level *(select the most appropriate option)*
☐ Nurse-Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

Home Medications *(include over-the counter)*

Health Care Practitioner Name LAST FIRST (**Please print and circle one:** MD, DO, NP, PA)		Signature	Date __ __/__ __/__ __ __ __
Address		Tel. (___)___-____	Fax. (___)___-____
NYS License # **(Required)**	NPI # __ __ __ __ __ __ __ __ __ __		

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 4/20 **PARENTS MUST SIGN PAGE 2 ➔**

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2020–2021

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

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse my child's medicine and equipment. I will try to give the school epinephrine pens with retractable needles.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma or epinephrine medicines are not available.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
   - 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 medication administration form (MAF), I authorize the Office of School Health (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 medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (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 allergy 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 for 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.

SELF-ADMINISTRATION OF MEDICATION (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child epinephrine if my child is temporarily unable to carry and give him or herself medicine.

NOTE: If you decide to use stock, you must send your child's epinephrine, asthma inhaler and other approved self-administered medications on a school trip day and/or after school programs in order that he/she has it available. Stock medications are only for use by OSH staff in school only.

Student Last Name First Name MI	Date of Birth __ __ / __ __ / __ __ __ __	
School ATSDBN/Name	Borough	District
Parent/Guardian's Name (Print) SIGN HERE	**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**	**Contact 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 ☐ Modified ☐ Not Modified

*Confidential Information should not be sent by email

FOR PRINT USE ONLY

Attach student photo here

GENERAL MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR DIABETES, SEIZURE, ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form I Office of School Health I School Year **2022-2023**

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

Student Last Name: _____ First Name: _____ Middle: _____ Date of birth: _____

OSIS Number: _____ Sex: ☐ Male ☐ Female

School (include name, number, address, and borough): _____ DOE District: _____ Grade: _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

1. Diagnosis:_____ **ICD-10 Code: ☐ ____. ____**

Medication (Generic and/or Brand Name): _____

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level (select the most appropriate option):

☐ Nurse-Dependent Student: nurse must administer

☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/ self-administer - *Initial below for Independent (Not allowed for controlled substances)

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

In School Instructions

☐ Standing daily dose – at _____ and _____ **and/or**

☐ PRN - specify signs, symptoms, or situations: _____

☐ Time Interval: _____ minutes or _____ hours as needed

☐ If no improvement, repeat in _____ minutes or _____ hours for a maximum _____ of times.

Conditions under which medication should not be given:_____

2. Diagnosis:_____ **ICD-10 Code: ☐ ____. ____**

Medication (Generic and/or Brand Name): _____

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level (select the most appropriate option):

☐ Nurse-Dependent Student: nurse must administer

☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/ self-administer - * Initial below for Independent (Not allowed for controlled substances)

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

In School Instructions

☐ Standing daily dose – at _____ and _____ **and/or**

☐ PRN - specify signs, symptoms, or situations: _____

☐ Time Interval: _____ minutes or _____ hours as needed

☐ If no improvement, repeat in _____ minutes or _____ hours for a maximum _____ of times.

Conditions under which medication should not be given:_____

3. Diagnosis:_____ **ICD-10 Code: ☐ ____. ____**

Medication (Generic and/or Brand Name): _____

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level (select the most appropriate option):

☐ Nurse-Dependent Student: nurse must administer

☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/ self-administer - * Initial below for Independent (Not allowed for controlled substances)

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

In School Instructions

☐ Standing daily dose – at _____ and _____ **and/or**

☐ PRN - specify signs, symptoms, or situations: _____

☐ Time Interval: _____ minutes or _____ hours as needed

☐ If no improvement, repeat in _____ minutes or _____ hours for a maximum _____ of times.

Conditions under which medication should not be given:_____

Home Medications (include over the counter) ☐ None

Health Care Practitioner Last Name:_____ First Name: _____ Signature: _____

Please select one: ☐ MD ☐ DO ☐ NP ☐ PA

Address: _____ E-mail address: _____

Tel. No: _____ FAX No: _____ Cell Phone: _____

NYS License No (Required): _____ NPI No: _____ Date: _____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

Rev 2/22

PARENTS MUST SIGN PAGE 2 →

GENERAL MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR DIABETES, SEIZURE, ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form | Office of School Health | School Year 2022-2023

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

PARENTS/GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.

2. **I understand that:**

- I must give the school nurse my child's medicine and equipment.
- **All prescription and "over-the-counter" medicine | give the school must be new, unopened, and in the original bottle or box.** I will provide the school with current, unexpired medicine for my child's use during school days.
    - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
- I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
- **No student is allowed to carry or give him or herself controlled substances.**
- 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 medication administration form (MAF), OSH may 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 medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (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.
- This form represents my consent and request for the medication 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-ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself, the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

Student Last Name: _____ First Name: _____ MI: _____ Date of birth: _____

School (ATS DBN/Name): _____ Borough: _____ District: _____

Parent/Guardian Name (Print): _____ Parent/Guardian's Email: _____

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Address: _____

Telephone Numbers: Daytime: _____ Home_____ Cell Phone: _____

Alternate Emergency Contact:

Name: _____ Relationship to Student: _____ Phone Number:_____

For Office of School Health (OSH) Use Only

OSIS Number: _____ **Received by -** Name: _____ Date: _____

☐ 504 ☐IEP ☐ Other: _____ **Reviewed by -** Name: _____ Date: _____

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 email