Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2025–2026**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

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

Sex: ☐ Male ☐ Female OSIS Number: _____ Grade: _____ Class: _____ DOE District: _____

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

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergies: _____

History of asthma? ☐ Yes (If yes, student has an increased risk for a severe reaction; complete the Asthma MAF for this student
☐ No

Does this student have the ability to:

Self-Manage (See 'Student Skill Level' below)	☐ Yes	☐ No
Recognize signs of allergic reactions	☐ Yes	☐ No
Recognize and avoid allergens independently	☐ Yes	☐ No

Select In-School Medications

SEVERE ALLERGIC REACTION

A. Immediately administer epinephrine ordered below, then call 911. **Weight: _____ kg**

Injectable (IM) ☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg **Intranasal** ☐ 1 mg ☐ 2 mg

Give epinephrine for any of the following signs and symptoms:

- 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 signs/symptoms after a sting or eating these foods, give epinephrine and call 911.

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

☐ If this box is checked, give antihistamine after epinephrine administration (order antihistamine below)

Student Skill Level (select the most appropriate option):

☐ Nurse-Dependent Student: 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 during school, field trips, and school sponsored events - Practitioner's Initials: _____

MILD ALLERGIC REACTION (parent must supply medicine for use in medical room)

Give for any of the following signs and symptoms: • few hives • itchy mouth/nose/skin • mild nausea

Name: _____ Preparation/Concentration:_____ Dose:_____ PO ☐ Q4 hours ☐ Q6 hours ☐ Q24 hours prn

Student SkillLevel (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 during school, field trips, and school sponsored events - Practitioner's Initials: _____

OTHER ALLERGY MEDICATION

- Give Name:_____ Preparation/Concentration:_____ Dose: _____ PO Q_____ hours prn

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 during school, field trips, and school sponsored events - Practitioner's Initials: _____

Home Medications (include over the counter) ☐ **None**

Health Care Practitioner

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

Signature: _____ Date: _____ NYS License # (Required): _____ NPI #: _____

Address: _____ E-mail address: _____

Tel: _____ FAX: _____ Cell Phone: _____

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM Provider

Medication Order Form | Office of School Health | School Year **2025–2026**

Please return to School Nurse/School Based Health Center. 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/school based health center (SBHC) provider 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/SBHC provider 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/SBHC provider a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse/ SBHC provider a new MAF written by my child's health care practitioner.
   - This form represents my consent and request for the allergy services described on this form, and may be sent directly to OSH. 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 Section 504 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.

NOTE: If you decide to use stock medication, you must send your child's epinephrine, asthma inhaler and other approved medications with your child for a school trip day and/or an after school program. Stock medications are only foruse in school by OSH staff.

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 and on trips. 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/SBHC provider 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.

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: _____

Parent/Guardian Cell Phone: _____ Other Phone _____

Other Emergency Contact Name/Relationship: _____

Other Emergency Contact Phone: _____

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 per Office of School Health after consultation with prescribing practitioner: ☐ Clarified ☐ Modified