



FÒM POU BAY MEDIKAMAN KONT OPRESYON

FÒM POU DOKTÈ PRESKRI MEDIKAMAN | Biwo Sante Lekòl | Ane lekòl 2023-2024

Tanpri voye I tounen ba enfimye/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: _____ Inisyal/Middle Initial: _____ Dat nesans: _____

Seks: Gason Fi Nimewo OSIS: _____ Distri DOE: _____

Lekòl (mete: ATS DBN/Non, adrès ak borough): _____ Nivo klas/Salklas: _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis

- Asthma
 Other: _____

Control (see NAEPP Guidelines)

- Well Controlled
 Not Controlled / Poorly Controlled
 Unknown

Severity (see NAEPP Guidelines)

- Intermittent
 Mild Persistent
 Moderate Persistent
 Severe Persistent
 Unknown

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

- History of near-death asthma requiring mechanical ventilation Y N U
History of life-threatening asthma (loss of consciousness or hypoxic seizure) Y N U
History of asthma-related PICU admissions (ever) Y N U
Received oral steroids within past 12 months Y N U _____ times last: _____
History of asthma-related ER visits within past 12 months Y N U _____ times last: _____
History of asthma-related hospitalizations within past 12 months Y N U _____ times last: _____
History of food allergy or eczema, specify: _____ Y N U
Excessive Short Acting Beta Agonist (SABA) use (daily or > 2 times a week)? Y N U

Home Medications (include over the counter) None

- Reliever: _____ Controller: _____ Other: _____

Student Skill Level (select the most appropriate option):

- Nurse-Dependent Student: nurse must administer medication
 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: _____

Quick Relief In-School Medication

**** If in Respiratory Distress: call 911 and give albuterol 6 puffs: may repeat Q 20 minutes until EMS arrives!**

- Albuterol [Only generic Albuterol MDI w/ individual spacer is provided by school; this will be used if prescribed medication below is unavailable]

Standard Order: Give 2 puffs q 4 hrs PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE.

Other Quick Relief Medication:

- Other Albuterol Dosing: Name: _____ Strength: _____ Dose: _____ puffs every _____ hours. If not symptom-free within 20 mins may repeat ONCE
 Airsupra (albuterol & budesonide) Strength _____ Dose _____ puffs PRN every _____ hrs. If not symptom-free within 20 mins may repeat ONCE
 Symbicort (formoterol & budesonide) Strength: _____ Dose: _____ puffs every _____ min or _____ hrs. May repeat ONCE PRN
 Albuterol with ICS: Albuterol _____ puffs followed by Flovent _____ puffs every _____ hrs. If not symptom-free in 20 mins may repeat ONCE
• Albuterol _____ puffs followed by Qvar _____ puffs every _____ hrs. If not symptom-free in 20 mins may repeat ONCE
 Albuterol MDI _____ puffs followed by ICS (Name) _____ Strength: _____ puffs every _____ hrs
 URI Symptoms/Recent Asthma Flare: 2 puffs @noon for 5 school days when directed by PCP
Name: _____ Dose: _____ puffs/ _____ AMP q _____ hrs.
 Pre-exercise: Name: _____ Dose: _____ puffs/ _____ AMP 15-20 mins before exercise.

Special Instructions:

Controller Medications for In-School Administration (Recommended for Persistent Asthma, per NAEPP Guidelines)

- Fluticasone [Only Flovent® 110 mcg MDI is provided by school for shared usage] Stock Parent Provided
Standing Daily Dose: _____ puff (s) one **OR** two time(s) a day Time: _____ AM and _____ PM
 Symbicort (provided by parent). Standing Daily Dose: _____ puff (s) one **OR** two time(s) a day Time: _____ AM and _____ PM
Special Instructions: _____
 Other ICS (provided by parent) Standing Daily Dose:
Name: _____ Strength: _____ Dose: _____ Route: _____ Frequency: one **OR** two time(s) a day Time: _____ AM & _____ PM

Health Care Practitioner

Last Name (Print): _____ First Name (Print): _____ MD DO NP PA

NYS License # _____ NPI # : _____ Signature: _____ Date: _____
Completed by Emergency Department Medical Practitioner: Yes No (ED Medical Practitioners will not be contacted by OSH/SBHC Staff)
Address: _____ E-mail address: _____
Tel: _____ FAX: _____ Cell Phone: _____

CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

FORMS CANNOT BE COMPLETED BY A RESIDENT

PARAN DWE SIYEN PAJ 2 A→

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. | REV 3/23

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PRESKRIPSYON DOKTÈ POU MEDIKAMAN KONT OPRESYON | Biwo Sante Lekòl | An
lekòl 2023-2024

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

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

- Mwen dakò pou yo konsève medikaman pitit mwen ak ba li yo nan lekòl la dapre eksplikasyon doktè pitit mwen an bay. Mwen dakò tou pou nenpòt ekipman yo bezwen pou yo ka konsève ak itilize medikaman pitit mwen an nan lekòl la.
- Mwen konprann ke:
 - Mwen dwe bay enfimye/Sant sante (SBHC) ki nan lekòl la medikaman ak ekipman pitit mwen an tankou ponp ki pa gen albitewòl (non-albuterol).
 - Tout medikaman sou preskripsyon ak tout medikaman “ki vann san preksripsyon (over-the-counter)” fèt pou nèf, kachte nan bwat oswa boutèy orijinal la. M ap bay lekòl la medikaman ki resan, ki pa ekspire pou pitit mwen itilize pandan jounen lekòl la.**
 - Medikaman ki vann sou preskripsyon yo fèt pou gen etikèt **orijinal** famasi a sou bwat la oswa sou boutèy la. Etikèt la dwe gen ladan: 1) non pitit mwen an, 2) non ak nimewo telefòn famasi a, 3) non doktè pitit mwen an, 4) dat, 5) kantite rechaj (refills), 6) non medikaman an, 7) kantite dòz, 8) lè pou li pran l, 9) kòman pou li pran medikaman an ak 10) nenpòt lòt eksplikasyon.
 - Mwen sètifye/konfime mwen pale avèk doktè pitit mwen an epi mwen bay konsantman m pou OSH/ SBHC ba pitit mwen an medikaman ki disponib nan lekòl la nan ka kote medikaman kont opresyon pitit mwen an pa ta disponib.
 - Mwen dwe di enfimye/founisè SBHC lekòl la **imedyatman** nenpòt chanjman ki genyen nan medikaman pitit mwen an oswa nan eksplikasyon doktè k ap trete l.
 - OSH ak ajan li ki patisipe nan ofri pitit mwen an sèvis sante ki pi wo yo konte sou prezizyon ki nan enfòmasyon ki sou fòm sa a.
 - Lè m siyen fòm pou bay medikaman sa a (medication administration form, MAF) sa a, mwen otorize Biwo sante lekòl (Office of School Health, 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 enfimye OSH/SBHC fè.
 - Preskripsyon medikaman ki sou fòm MAF sa a ekspire nan fen ane lekòl pitit mwen an, ki ka gen ladan tou sesyon ete, oswa lè mwen bay enfimye lekòl la/founisè SBHC a yon nouvo fòm MAF (kèlkeswa sa ki rive avan an).
 - Lè preskripsyon medikaman sa a ekspire, m ap bay enfimye/founisè SBHC lekòl pitit mwen an yon nouvo fòm MAF ke doktè pitit mwen an ap ekri. Si w pa fè sa, yon doktè OSH/SBHC ka konsilte pitit mwen an sofsi mwen bay enfimye/SBHC lekòl la yon lèt ki di mwen pa vle yon ajan sante OSH/ SBHC konsilte pitit mwen an. Doktè OSH/SBHC a ka evalye sentòm opresyon an ak efè medikaman yo preskri kont opresyon an sou pitit mwen an. Doktè OSH/SBHC a ka deside si preskripsyon medikaman yo pral rete menm jan oswa si yo bezwen chanje yo. Doktè OSH/SBHC a ka ranpli yon nouvo fòm MAF pou pitit mwen an ka kontinye resevwa sèvis sante nan OSH/SBHC. Doktè m lan oswa Doktè OSH/SBHC a p ap bezwen siyati m pou l ekri lòt fòm MAF pou opresyon alavni. Si doktè OSH/HBSC a ranpli yon nouvo fòm MAF pou pitit mwen an, doktè OSH/HBSC a pral eseye enfòm mwen menm ak doktè pitit mwen an.
 - Fòm sa a reprezante konsantman m ak demand mwen fè pou pou sèvis opresyon ki sou fòm sa a. Se pa yon akò OSH/HBSC genyen pou li bay sèvis ou mande a. Si OSH/SBHC 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/SBHC ka gen nenpòt lòt enfòmasyon yo panse ki nesèse sou pwoblèm medikal pitit mwen an, medikaman l ap pran oswa tretman l suiv. OSH/ OSH ka pran enfòmasyon sa a nan men nenpòt doktè, enfimye oswa famasyon ki bay pitit mwen an sèvis.

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 pran medikaman poukont li. Mwen dakò pou pitit mwen an pote, konsève ak pran poukontli medikaman yo preskri nan fòm sa a nan lekòl la. Mwen gen responsablite pou bay pitit mwen an medikaman sa a nan boutèy oswa nan bwat yo jan yo dekri sa pi wo a. Mwen gen responsablite pou m sipèvize itilizasyon medikaman pitit mwen an, ak pou tout konsekans ki genyen nan itilizasyon medikaman pitit mwen an pran nan lekòl la. Enfimye/SBHC lekòl la pral konfime kapasite pitit mwen an pou l pote ak pran medikaman yo poukont li. Mwen dakò tou pou m bay lekòl la medikaman “an rezèv” nan yon bwat oswa boutèy ki gen etikèt byen klè sou li.

SONJE: Si ou chwazi pou itilize medikaman ki nan estòk nan lekòl la, ou dwe voye ponp opresyon, epinephrine pitit ou a ak lòt medikaman apwouve li gen pou pran poukont li nan pwomnad lekòl la ak/oswa nan pwogram aprelekòl pou li ka genyen yo disponib. Medikaman ki nan estòk lekòl yo se sèlman estaf OSH ki nan lekòl la ki pou itilize yo.

Siyati elèv la: _____ Non: _____ Dezyèm non: _____ Dat nesans: _____

Lekòl (ATS DBN/Non): _____ Borough: _____ Distri: _____

Non paran/responsab (ekri byen klè): _____ Imèl paran/responsab la: _____

Siyati paran/responsab: _____ Dat fòm lan siyen: _____

Adrès paran/responsab: _____

Selilè paran/responsab: _____ Lòt telefòn: _____

Non/relasyon lòt moun yo ka kontakte pou ijans: _____

Telefòn lòt moun yo ka kontakte pou ijans lan: _____

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 OSH Asthma Case Manager (For supervised students

only) Signature and Title (RN OR MD/DO/NP): _____

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

Confidential information should not be sent by email

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