Attach student photo here

GENERAL MEDICATION ADMINISTRATION FORM

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

Provider Medication Order Form | The Parkside School | School Year **2023-2024**

Student Last Name First Name Middle | **Date of birth** __ __ / __ __ / __ __ __ __ MM DD YYYY | ☐ Male ☐ Female

Grade/Class _____

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 medication
- ☐ 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)

Practitioner's Initials _____

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

In School Instructions *(please specify AM / PM)*

☐ Standing daily dose: at __ __ : __ __ AM / PM and __ __ : __ __ AM / PM

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:

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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 medication
- ☐ 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)

Practitioner's Initials _____

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

In School Instructions

☐ Standing daily dose: at __ __ : __ __ AM / PM and __ __ : __ __ AM / PM

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:

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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 medication
- ☐ 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)

Practitioner's Initials _____

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

In School Instructions

☐ Standing daily dose: at __ __ : __ __ am / pm and __ __ : __ __ AM / PM

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)

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

PARENTS MUST SIGN PAGE 2 ➔

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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.
   - **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 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 Parkside School 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), RN may provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by The Parkside School's 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.
   - For the purposes of providing care or treatment to my child, RN may obtain any other information they think is needed about my child's medical condition, medication or treatment. RN 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 __ __ / __ __ / __ __ __ __

Select Borough

Print Parent/Guardian's Name	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 The Parkside School Administrative Use Only

Received by: Name	Date __ __ / __ __ / __ __ __ __	**Reviewed by**: Name	Date __ __ / __ __ / __ __ __ __
☐ **504** ☐ **IEP** ☐ **Other**			☐ ☐
Services provided by: ☐ Nurse/NP	☐		☐
Signature and Title (RN OR SMD):		**Date School Notified & Form Sent to DOE Liaison**	__ __ / __ __ / __ __ __ __
Revisions as per RN contact with prescribing health care practitioner		☐ Modified	☐ Not Modified

*Confidential Information should not be sent by email

FOR PRINT USE ONLY