

MULTI-USE MEDICATION FORM

Authorization for Administration of Medication to Students for the School Year 2004-2005

Student's Name (Last, First, Middle)		Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth	I.D. Number
Region	School	Grade	Class	Borough
School Address				Zip Code

FOR DOE/DOHMH USE:

MS
 504
 IEP
 SC/SA

Physician's Order	Order for Administration in School	Instructions in case of lack of improvement or adverse reaction	Choose all that are appropriate
<p>1. Diagnosis ASTHMA <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>INDICATE SEVERITY:</p> <p><input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Moderate Persistent</p> <p><input type="checkbox"/> Mild Persistent <input type="checkbox"/> Severe Persistent</p>	<p>For your convenience, we have pre-printed a standard albuterol order. If you are not in agreement please re-write the order in box #2. If no box is checked, we will implement the first standard order:</p> <p><input type="checkbox"/> Albuterol 2 puffs q 4 hrs. via metered dose inhaler and spacer prn cough, wheeze, tightness in chest, difficulty breathing or shortness of breath. May repeat in 15 mins x 2 if no improvement (3 total).</p> <p><input type="checkbox"/> Albuterol 2 puffs via MDI with spacer 15-30 minutes before exercise.</p>	<p>If improved, but not enough to return to class, call parent. If significant respiratory distress persists, call 911 and notify parent and PMD. May provide additional puffs as needed until EMS arrives.</p>	<p><input type="checkbox"/> Store medication in medical room and administer under supervision.</p> <p><input type="checkbox"/> Student may carry medication and may self-administer. <i>(Parent must initial reverse side.)</i></p>
<p>2. Diagnosis _____</p> <p>Medication/Preparation _____</p> <p>Dose/Route _____</p> <p><input type="checkbox"/> Diagnosis substantially controlled with medication. <input type="checkbox"/> Diagnosis not substantially controlled with medication. <input type="checkbox"/> Diagnosis self-limited.</p>	<p><input type="checkbox"/> Standing daily dose. Specify time(s): _____ Conditions under which medication should not be given: _____</p> <p>----- AND/OR -----</p> <p><input type="checkbox"/> prn _____ <i>specific signs, symptoms or situations</i></p> <p>Time interval: q _____ hours as needed Any repeats if _____ in _____ hr; max _____ times no improvement? <input type="checkbox"/> Yes, in _____ min, max _____ times</p>		<p><input type="checkbox"/> Store medication in medical room and administer under supervision.</p> <p><input type="checkbox"/> Student may carry medication (includes epi pen and MDI) and may self-administer. <i>(Parent must initial reverse side.)</i></p> <p>NOT FOR CONTROLLED SUBSTANCES.</p>
<p>3. Diagnosis _____</p> <p>Medication/Preparation _____</p> <p>Dose/Route _____</p> <p><input type="checkbox"/> Diagnosis substantially controlled with medication. <input type="checkbox"/> Diagnosis not substantially controlled with medication. <input type="checkbox"/> Diagnosis self-limited.</p>	<p><input type="checkbox"/> Standing daily dose. Specify time(s): _____ Conditions under which medication should not be given: _____</p> <p>----- AND/OR -----</p> <p><input type="checkbox"/> prn _____ <i>specific signs, symptoms or situations</i></p> <p>Time interval: q _____ hours as needed Any repeats if _____ in _____ hr; max _____ times no improvement? <input type="checkbox"/> Yes, in _____ min, max _____ times</p>		<p><input type="checkbox"/> Store medication in medical room and administer under supervision.</p> <p><input type="checkbox"/> Student may carry medication (includes epi pen and MDI) and may self-administer. <i>(Parent must initial reverse side.)</i></p> <p>NOT FOR CONTROLLED SUBSTANCES.</p>

List medication(s) student is taking at home and at what time:

Physician's Name		Physician's Signature	
Physician/Clinic Address			
Physician/Clinic Tel. No.	Physician/Clinic Fax No.	NYS Registration No.	Date

FOR DOHMH USE: Revisions per DOHMH
