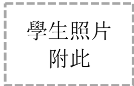

GENERAL MEDICATION ADMINISTRATION FORM

本表不應用於糖尿病、癲癇、哮喘或過敏藥物

提供者藥物要求表 | 學校健康辦公室 | **2024-2025**學年

請交還給學校護士。6月1日之後遞交的表格可能會對新學年的申請程序造成延誤。

學生姓氏: ____________ 名字: ____________ 中間名: ________ 出生日期:（月/日/年） ________

性別：☐ 男 ☐ 女 學生身份號碼(OSIS): ________ 年級: ________ 班級: ________

學校（包括名稱、號碼、地址和行政區）：____________________ 教育局學區: ________

健康護理人員填寫以下部分 / 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 (Print): ____________ First Name (Print): ____________ **Please check one:** ☐ MD ☐ DO ☐ NP ☐ PA

Signature: ____________ Date: ________ NYS License # (Required): ________ NPI #: ________

Address: ____________ Email address: ____________

Telephone: ____________ FAX: ____________ Cell Phone: ____________

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

更新於3月24日

家長必須在第2頁簽名 / **PARENTS MUST SIGN PAGE 2** ☐

GENERAL MEDICATION ADMINISTRATION FORM

本表不應用於糖尿病、癲癇、哮喘或過敏藥物

提供者藥物要求表 | 學校健康辦公室 | **2024-2025**學年

請交還給學校護士。6月1日之後遞交的表格可能會對新學年的申請程序造成延誤。

家長/監護人：通讀、填寫並簽名。我在下面簽名，表示我同意如下：

1. 我同意，學校保存我子女的醫藥並根據我子女的保健專業人員的說明給藥。我也同意，我子女的醫藥所需的任何器材都在學校裏儲存和使用。
2. **我理解：**
   - 我必須把我子女的醫藥和器材交給學校護士。
   - **我給予學校的所有處方和非處方藥物都必須是新的、未曾開封過並裝在其原封瓶子或盒子裏。**我將給學校提供我子女在上學日內需使用的當前、未過期的醫藥用品。
     - 處方藥物必須在其盒子或瓶子上有**原裝**藥房標籤。標籤必須包括：1) 我子女的姓名， 2) 藥房名稱和電話號碼， 3) 我子女的保健專業人員姓名， 4) 日期， 5) 重配次數， 6) 藥物名稱， 7) 劑量， 8) 何時用藥， 9) 如何用藥 以及 10) 任何其他說明。
   - 如果我子女的藥物發生任何變化或者保健專業人員的說明有任何變化，我必須**立即**告知學校護士。
   - **學生不得攜帶或自我施用受管制的藥物.**
   - 涉及到給我子女提供上述健康服務的學校健康辦公室（OSH）及其代理人員依賴於本表資訊的精確度。
   - 我在這一「藥物施用表」（MAF）上簽名，則學校健康辦公室（OSH）可以為我子女提供健康服務。這些服務可以包括（但不限於）由一名OSH辦公室保健專業人員或護士所執行的臨床評估或體檢。
   - 這份MAF表的醫療執行手續的過期時間是我子女的學年結束（這可能包括暑期班）或者當我交給學校護士一份新的MAF（取兩者中較早的那個時間）。當這份醫療手續執行要求過期時, 我將交給我子女的學校護士一份新的由我子女的保健專業人員出具的MAF。
   - 這份表格代表我對本表所說明的醫療服務的同意和要求。這並非OSH提供所要求的服務的協議。如果OSH決定提供這些服務，我子女可能還需要一份「學生特別照顧計劃」（Student Accommodation Plan）。這份計劃將由學校填寫。
   - 爲著給我子女提供護理或治療的目的，OSH可以獲取該辦公室認爲有關我子女的醫療狀況、藥物和治療而需要的任何其他資訊。OSH可以向任何為我子女提供健康服務的保健專業人員、護士或藥劑師索取該資訊。

註：最好是您在學校外出參觀的日子和在校外進行學校活動時給子女帶上藥物和器材。

自己用藥（僅適用於能自己獨立用藥的學生）：

- 我證明/確認，我子女已得到完全的訓練並能夠自行用藥。我同意，我子女在學校裏以及在參加學校旅行時自己攜帶、儲存本表所開具的藥物並將自己用藥。我負責根據上述說明把瓶子或盒子裏的藥物交給我子女。我也負責監督我子女在學校裏的藥物使用情況及其對這一藥物使用所產生的任何結果。學校護士將確認我子女擁有攜帶和自行用藥的能力。我也同意交給學校「備用」藥物（裝在清楚地標示的盒子或瓶子裏）。

學生姓氏: ____________ 名字: ____________ 中間名首字母: ___ 出生日期:（月/日/年）____________

學校（ATS DBN/名稱）：____________ 行政區：________ 學區：______

家長/監護人姓名（用英文清楚書寫）:____________ 家長/監護人電子郵箱: ____________

家長/監護人簽名: ____________ 簽名日期: ____________

家長/監護人地址: ____________

電話號碼： 日間: ____________ 住宅: ____________ 手機: ____________

其他緊急聯絡人：

姓名: ____________ 與學生的關係: ____________ 電話號碼: ____________

僅供學校健康辦公室（OSH）工作人員填寫 / For Office of School Health (OSH) Use Only

OSIS #: ____________ **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 OSH contact with prescribing health care practitioner: ☐ **Clarified** ☐ **Modified**

Confidential information should not be sent by email ./ 機密資料不應用電郵傳送。 更新於3月24日