

Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2021-2022

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year

Student Last Name	First Name	Middle	Date of birth ___/___/____ MM DD YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
OSIS Number _____	Weight _____ kg			
School (include ATSDBN/name, number, address and borough)			DOE District	Grade
			Class	

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	Specify Allergy	Specify Allergy	Specify Allergy
<input type="checkbox"/> Allergy to	<input type="checkbox"/> Allergy to	<input type="checkbox"/> Allergy to	<input type="checkbox"/> Allergy to
History of asthma? <input type="checkbox"/> Yes (If yes, student has an increased risk for a severe reaction; complete the Asthma MAF for this student) <input type="checkbox"/> No	Does this student have the ability to:		
History of anaphylaxis? <input type="checkbox"/> Yes Date ___/___/____ <input type="checkbox"/> No	Self-Manage (See 'Student Skill Level' below)		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, system affected <input type="checkbox"/> Respiratory <input type="checkbox"/> Skin <input type="checkbox"/> GI <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Neurologic	Recognize signs of allergic reactions		<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment	Date ___/___/____	Recognize/avoid allergens independently	<input type="checkbox"/> Yes <input type="checkbox"/> No

Select In School Medications

1. SEVERE REACTION

A. Immediately administer epinephrine ordered below, then call 911.

- 0.15 mg
- 0.3 mg

Give intramuscularly in the anterolateral thigh for any of the following signs/symptoms (retractable devices preferred):

- Shortness of breath, wheezing, or coughing
- Fainting or dizziness
- Lip or tongue swelling that bothers breathing
- Pale or bluish skin color
- Tight or hoarse throat
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Weak pulse
- Trouble breathing or swallowing
- Feeling of doom, confusion, altered consciousness or agitation
- Many hives or redness over body

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.

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/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

2. MILD REACTION

A. Give antihistamine: Name: _____ Preparation/Concentration: _____ Dose: _____ Route: _____

Frequency: Q4 hours or Q6 hours as needed for any of the following signs/symptoms:

- Itchy nose, sneezing, itchy mouth
- A few hives or mildly itchy skin
- Mild stomach nausea or discomfort
- Other: _____

B. If signs/symptoms of severe allergy/anaphylaxis develop, or if more than one sign/symptom from each system is present, use epinephrine and call 911.

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

3. OTHER MEDICATION

• Give Name: _____ Preparation/Concentration: _____ Dose: _____

Route: _____ Frequency: Q _____ minutes hours as needed

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 Name LAST
(Please print and circle one: MD, DO, NP, PA)

FIRST

Signature

Date ___/___/____

Address

Tel. (____) _____ - _____ Fax. (____) _____ - _____

NYS License # (Required)

NPI #

