



THE NEW YORK CITY DEPARTMENT OF EDUCATION
JOEL I. KLEIN, *Chancellor*

**Guidelines For the Provision of Health and Educational Services For Students
in the New York City Public Schools
2005-2006**

To All Parents, Physicians, and Health Care Providers:

The New York City Department of Education and the New York City Department of Health and Mental Hygiene's Office of School Health work collaboratively to make certain that all students with special needs are provided services to ensure their participation in the educational setting. To this end, parents and providers must use the enclosed forms, for all requests for in school direct health and educational services. **These forms must be returned to the child's school for processing.** A new request and authorization form will be required for each school year if the child continues to require the requested services in school. The following guidelines should be followed in order to facilitate the review of the completed forms and to provide clinically appropriate services:

- The physician/health care provider completing the form should be the one who will be actively managing the condition for which services are requested.
- A NYS license number must be provided. Therefore, if a physician-in-training without a license number completes the form, it must be counter-signed by a supervisor (e.g., attending physician) and include the supervisor's license number.
- The order should be specific, legible and clearly written so that it is completely understandable to the nurse and can be carried out in a clinically responsible way.
- Only those services that must be performed during school hours should be requested, (e.g., if medication can be given at home before or after school hours, it should not be requested in school).
- Please note that medication is typically stored in a locked cabinet in a designated room (i.e., medical room) unless the student is authorized by you to carry medication in school.
- Parents, physicians, school staff and students must work together to encourage each child to be as self-sufficient as possible. If the child is able to self-administer the medication, the parent should initial the appropriate area on the back of the medication form. Most students at the intermediate and high school level should be self-directed in taking medications, (i.e., identify that the medication is the correct one; identify what the medication is for; determine that the correct dosage or amount is being administered; identify when the medication is needed during the school day; describe what will happen if it is not taken). Those students are then permitted to carry and self-administer only those medications that are necessary during the school day without supervision, except that **students are never permitted to carry controlled substances.**

Please remind parents to attach a small photograph to the upper left corner of the Medication Form for proper identification of the student.

There are five types of request and authorization forms:

- Medication Form - should be completed only for requests involving administration of medication for students. For cases of asthma, providers may attach an Asthma Action Plan with the Medication Form.
- Provision of Medically Prescribed Treatment (Non-Medication) - should be completed when requesting special procedures such as bladder catheterization, postural drainage, tracheal suctioning, gastrostomy tube feeding, etc. This form may be used for all skilled nursing treatments.
- Glucose Monitoring Form - should be completed for students with Diabetes.
- Insulin Pump Form - should be completed only for students using an insulin pump.
- Request for Educational Service(s) - should be used when requesting special services such as a barrier-free building, elevator use, testing modification, etc. This form should **NOT** be used for Related Services such as occupational therapy, physical therapy, speech and language therapy, counseling, etc. which is properly addressed and provided by a student's Individualized Education Program (IEP).

Please contact the student's school if you have any questions. Thank you for your assistance.

GLUCOSE MONITORING FORM

Authorization Monitoring Blood Sugar and Dietary Needs for the School Year 2005-2006

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

FOR DOE/DOHMH USE:	
<input type="checkbox"/>	MS
<input type="checkbox"/>	504
<input type="checkbox"/>	IEP
<input type="checkbox"/>	SC/SA

Physician's Order

The school's medical room is available for glucose monitoring. At the elementary school level, services are provided by a Registered Nurse. At the JHS level, the student usually self-monitors, witnessed and supervised by a Public Health Advisor.

If a Registered Nurse is not available and a student is too symptomatic to self-monitor but able to take something by mouth, then the student will consume simple carbohydrates without testing. For treatment of severe hypoglycemia, you may wish to provide a glucagon order on a **Medication Form**.

1. Diagnosis:

- Diabetes Type I
- Diabetes Type II
- Other _____

2. This student:

- should be responsible for monitoring his/her own Blood Sugar
- must have his/her Blood Sugar monitored by school personnel.

3. Snacks:

Please specify time, type and amount of snacks, and where they should be kept:

In addition the student should be permitted to carry snacks and ingest one when he/she feels it is appropriate.

4. Monitor Blood Sugar:

(Check and complete sections below as needed):

4A. <input type="checkbox"/> Before Lunch:			4B. <input type="checkbox"/> Before Gym:			4C. <input type="checkbox"/> PRN:	
Hypoglycemia Blood Sugar < _____ mg/dl	Normal Blood Sugar readings between _____ and _____ mg/dl	Hyperglycemia Blood Sugar > _____ mg/dl	Hypoglycemia	Normal Blood Sugar readings between _____ and _____ mg/dl	Hyperglycemia Blood Sugar > _____ mg/dl	Hypoglycemia Blood Sugar < _____ mg/dl	Hyperglycemia Blood Sugar > _____ mg/dl
<input type="checkbox"/> Give simple carbohydrate: (type, amount) _____ _____ <input type="checkbox"/> Re-test in _____ minutes before proceeding to lunch <input type="checkbox"/> If repeat BS is < _____ mg/dl, repeat carbs and testing until BS is > _____	Child will proceed to lunch. No further monitoring required <input type="checkbox"/> Administer insulin. <i>If child is to receive insulin, please provide specific orders on a Medication Form</i> <i>For an insulin pump also complete an Insulin Pump Form</i>	<input type="checkbox"/> Check ketones and call parent/MD if positive <input type="checkbox"/> Administer insulin. <i>If child is to receive insulin, please provide specific orders on a Medication Form</i> <i>For an insulin pump also complete an Insulin Pump Form</i>	a. Mild BS < _____ mg/dl <input type="checkbox"/> Give simple carbohydrate and/or snack: _____ and proceed to gym b. Moderate-Severe BS < _____ mg/dl Child will not go to gym <input type="checkbox"/> Give the following simple carbohydrate: _____ Repeat testing and carbs until BS is > _____ mg/dl	Child will proceed to gym <input type="checkbox"/> Give snack prior to gym. If given, type and amount of snack: _____ _____	<input type="checkbox"/> Check ketones If negative, proceed to gym? <input type="checkbox"/> Yes <input type="checkbox"/> No If positive, call parent/MD: Child will not go to gym Other: _____ _____	<input type="checkbox"/> Give simple carbohydrate _____ _____ <input type="checkbox"/> Re-check in 15 minutes. If BS is still < _____, repeat carbs and testing until BS is > _____ <input type="checkbox"/> Once BS > _____, and if not time for meal/ snack, give a booster snack _____ _____ <input type="checkbox"/> Call parent <input type="checkbox"/> Call MD	If BS is > _____, call parent <input type="checkbox"/> Check ketones and call parent/MD if positive Other specific instructions: _____ _____ _____ <input type="checkbox"/> Repeat BS after _____ <i>(write time)</i>

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

FOR DOHMH USE: Revisions per DOHMH

MONITORING BLOOD SUGAR AND DIETARY NEEDS:
PARENT/GUARDIAN'S CONSENT, AUTHORIZATION AND RELEASE
2005-2006

I hereby authorize: (1) the monitoring of my child's blood sugar/dietary needs, and/or (2) the treatment of hypoglycemic episodes by the administration of snacks, on school premises, in accordance with the attached instructions of his/her physician. I understand that I must furnish all necessary snacks, equipment and supplies and that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.

I understand that this Authorization is only valid until the earlier of: (1) **June 30, 2006**; (This prescription may be extended through August if the student is attending a Department of Education sponsored summer program); or (2) such time that I deliver to the principal, his/her designee(s) and school nurse a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed monitoring and treatment.

By submitting this Glucose Monitoring Form, I am requesting that my child be provided with specific health services by the New York City Department of Education (the "Department") including the Department of Health and Mental Hygiene (DOHMH) through the Office of School Health. I have provided the full and complete information and instructions regarding the provision of the above-requested health service(s) in this Glucose Monitoring Form. I understand that the Department, its agents and its employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information and instructions that I have provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that I have provided here in this Glucose Monitoring Form. I am aware that it is my obligation to provide the type and amount of snacks that my child is to receive during the school day. I understand that it is my responsibility to provide all equipment and supplies necessary to perform the function of glucose monitoring.

I recognize that the Department and its agents have a responsibility to ensure a safe environment in the medical room and anywhere else where my child may test his or her blood sugar. I will make every effort to provide the school with safety lancets and other safer needle devices for the purpose of glucose monitoring and insulin administration.

I recognize that this form is not an agreement by the Department of Education to provide the services requested, but, rather, my request, consent, authorization and release for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department of Education, its employees, and agents, to consult with and to obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist.

Please Print Parent/Guardian's Name & Address Below:

Parent/Guardian's Signature

Date Signed

Daytime Telephone No./ Home Telephone No.

DO NOT WRITE BELOW
(FOR DOE AND DOHMH ONLY)

Student's Name: _____

OSIS No: _____

Received by: _____
Name Date

Reviewed by: _____
Name Date

Referred to School 504 Coordinator: Yes No

Services provided by: Nurse DOHMH Public Health Adv. School Based Clinic DOE School Staff

Self-Monitors: Yes No

Signature and Title: _____
(RN OR MD)

(Date school notified and form forwarded to DOE liaison)

INSULIN PUMP FORM School Year 2005-2006

FOR DOE/DOHMH USE: 504 IEP OTHER

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

Answer and Complete All Questions Clearly
(Check appropriate boxes; fill in blanks with requested values)

This student is on an Insulin Pump which utilizes _____ type insulin. Also complete **Medication Form**.

- Student is fully instructed and should be responsible for: giving boluses changing the infusion site
- The following services must be performed by a Registered Nurse: giving boluses changing the infusion site

A. Parameters: (Fill in the requested information)

- Basal Rate in school:** _____ units/hr.
 Programs a temporary Basal Rate before gym: _____ units/hr.
- Target** _____ mg/dl with a Target Range of _____ mg/dl to _____ mg/dl.
- Sensitivity Factor:** 1 unit of insulin will decrease the BS by _____ mg/dl
- Insulin Carbohydrate Ratio:** 1: _____.

B. Insulin Administration

1. Before Lunch:

NORMOGLYCEMIA For BS within the target range	HYPERGLYCEMIA For BS above the upper limit of the target range, or BS > _____	HYPOGLYCEMIA For BS below the lower limit of the target range, or BS < _____
<p>Bolus insulin following the insulin/carbohydrate ratio:</p> <p>_____ gms. carbs in lunch divided by ratio _____ = _____ units of insulin</p> <p>Please complete the above <i>example</i> by choosing a typical amount of lunch carbohydrates for this student. <i>Actual</i> bolus will vary with carbohydrate content of lunch.</p>	<p>Give usual pre-lunch bolus plus a CORRECTION:</p> <p>Fill in the pre-lunch insulin bolus from the previous example: _____ units plus</p> <p>BS _____ minus Target _____ divided by Sensitivity _____ = _____ units of insulin</p> <p>Add above pre-lunch bolus _____ plus correction of _____ units of insulin = _____ units of insulin to be administered pre-lunch. Actual bolus will vary based on carbo content of lunch and degree of high BS.</p>	<p><input type="checkbox"/> OPTION 1: Takes _____ simple carbs before lunch. Calculate usual pre-lunch bolus, not counting the extra simple carbs. or</p> <p><input type="checkbox"/> OPTION 2: Administer a reduced pre-lunch insulin bolus</p> <p>Target _____ minus BS _____ divided by Sensitivity _____ = _____ units of insulin SUBTRACTED from pre-lunch bolus which is calculated as usual.</p>

2. After a High Blood sugar:

- If BS is > _____ mg./dl. re-test BS _____ hour(s) later.
- If BS has dropped but is still above the upper limit of the Target Range use the Sensitivity Factor formula to program an insulin bolus.
- Other _____
If the BS has not dropped or is higher pump may be malfunctioning. Call parent.

Specific instructions for suspected pump failure:

(Please choose from the following options which may be performed in the medical room under supervision):

- Change infusion site. After changing site use the Sensitivity Factor Formula to program an insulin bolus.
or
- Administer insulin by syringe (Order on **Medication Form**)

3. Before snacks:

- Tests BS before snacks and **programs an insulin bolus** as above.
- Other _____

4. Other Orders:

Physician's Signature	
Physician's Name (Print)	
Physician/Clinic Address	
Borough	Zip Code
NYS Registration No.	Date Signed
Physician/Clinic Telephone No.	Physician/Clinic Fax No.

FOR DOHMH USE: Revisions per DOHMH

PROVISION OF MEDICALLY PRESCRIBED INSULIN PUMP: PARENT/GUARDIAN'S CONSENT, AUTHORIZATION AND RELEASE
2005-2006

I hereby authorize the provision of medically prescribed treatment in accordance with the attached instructions of my child's physician. I understand that I must furnish all necessary equipment and supplies and that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.

I understand that this Authorization is only valid until the earlier of: (1) **June 30, 2006**; (This prescription may be extended through August if the student is attending a Department of Education sponsored summer program); or (2) such time that I deliver to the principal and/or his/her designee (s) a new prescription or instructions issued by my child's physician regarding the provision of the above-prescribed treatment.

I recognize that the Department, its agents including The Department of Health and Mental Hygiene (DOHMH) through the Office of School Health has a responsibility to ensure a safe environment in the medical room and anywhere else where my child may test his or her blood sugar. I will make every effort to provide the school with safety lancets and other safer needle devices for the purpose of glucose monitoring and insulin administration.

By submitting this Insulin Pump Form, I am requesting that my child be provided with specific health services by the New York City Department of Education (the "Department"). I have provided the full and complete information and instructions regarding the provision of the above-requested health service(s) in this form. I understand that the Department, its agents, and its employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information and instructions that I have provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that I have provided here in this form. I understand that it is my responsibility to provide the insulin pump, all equipment, and supplies necessary for the provision of this request.

I recognize that this form is not an agreement by the Department of Education to provide the services requested, but, rather, my request, consent, authorization and release for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department of Education, its employees, and agents, to consult with and to obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist.

Please Print Parent/Guardian Name & Address Below:

Parent/Guardian's Signature

Date Signed

Daytime Telephone No. Home Telephone No.

**DO NOT WRITE BELOW
(FOR DOE AND DOHMH ONLY)**

Student's Name: _____

OSIS No: _____

Received by: _____
Name Date

Reviewed by: _____
Name Date

Referred to School 504 Coordinator: Yes No

Services provided by: Nurse DOHMH Public Health Adv. School Based Health Center DOE School Staff

Self-Directs Treatment: Yes No

Signature and Title: _____
(RN OR MD)

(Date school notified and form forwarded to DOE Liaison)

**REQUEST FOR PROVISION OF
MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)
2005-2006 SCHOOL YEAR**

FOR DOE/DOHMH USE: ? 504 ? IEP ? OTHER

Student's Name: Last: _____ First: _____ Middle: _____
Male: _____ Female: _____ D.O.B: _____ I.D. #: _____
Borough: _____ Region: _____ School: _____ Grade: _____ Class: _____
School Address: _____ Zip Code: _____

Part I: Physician's Statement/Order

(Attach prescription(s)/additional sheet(s) if necessary to provide requested information and medical authorization).

Clean Intermittent Catheterization

Central Venous Line

Gastrostomy Feeding

Naso-Gastric Feeding

Tracheostomy Care

Oral/Pharyngeal Suctioning

Oxygen Administration

Ostomy Care

Chest Clapping

Percussion

Postural Drainage

Dressing Change

Other _____

1. Diagnosis _____
2. Treatment required in school _____

3. Specific instructions for providing treatment _____

4. Frequency/time to be provided _____
5. Conditions under which treatment should not be provided _____
6. Date(s) when treatment should be initiated _____ terminated _____
7. Possible side effects/adverse reactions to treatment _____

8. Specific instructions for non-medical school personnel in case of adverse reactions _____

9. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions _____

10. Diagnosis is substantially controlled with provision of medically prescribed treatment Yes _____ No _____
11. Diagnosis is self - limited Yes _____ No _____

Physician's Name (Print)

Physician's Signature

Physician/Clinic's Address

NYS Registration No.

Date Signed

Zip Code

Physician/Clinic's Telephone No.

Physician/Clinic's Fax No.

FOR DOE/DOHMH USE: Revisions as per DOE/ DOHMH contact with prescribing physician

**PROVISION OF MEDICALLY PRESCRIBED TREATMENT:
PARENT/GUARDIAN'S CONSENT, AUTHORIZATION AND RELEASE
2005-2006**

I hereby authorize the provision of medically prescribed treatment in accordance with the attached instructions of my child's physician. I understand that I must furnish all necessary equipment and supplies and that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.

I understand that this Authorization is only valid until the earlier of: (1) **June 30, 2006**; (This prescription may be extended through August if the student is attending a Department of Education sponsored summer program; or (2) such time that I deliver to the principal and/or his/her designee (s) a new prescription or instructions issued by my child's physician regarding the provision of the above-prescribed treatment.

By submitting this Request for Provision of Medically Prescribed Treatment (Non-Medication) Form, I am requesting that my child be provided with specific health services by the New York City Department of Education (the "Department") including the Department of Health and Mental Hygiene (DOHMH) through the Office of School Health. I have provided the full and complete information and instructions regarding the provision of the above-requested health service(s) in this form. I understand that the Department, its agents and its employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information and instructions that I have provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that I have provided here in this form. I understand that it is my responsibility to provide all equipment and supplies necessary for the provision of the above-requested medically prescribed non-medication treatment.

I recognize that this form is not an agreement by the Department of Education to provide the services requested, but, rather, my request, consent, authorization and release for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department of Education, its employees and agents, to consult with and to obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

Please Print Parent/Guardian's Name & Address below:

_____	_____
Parent/Guardian's Signature	
_____	_____
Date Signed	
_____	_____
Daytime Telephone No./Home Telephone No.	

**DO NOT WRITE BELOW
(FOR DOE AND DOHMH ONLY)**

Student's Name: _____	OSIS No: _____
Received by: _____ Name Date	Reviewed by: _____ Name Date
Referred to School 504 Coordinator: ? Yes ? No	
Services provided by: ? Nurse ? DOH MH Public Health Adv. ? School Based Health Center ? DOE School Staff	
Self-Directs Treatment: ? Yes ? No	
Signature and Title: _____ (RN OR MD)	_____ (Date school notified and form forwarded to DOE liaison)

Parent must complete and SIGN reverse side of this Medication Form and submit to nurse along with a current photograph attached to upper left corner.

MULTI-USE MEDICATION FORM
Authorization for Administration of Medication to Students for the School Year 2005-2006

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

FOR DOE/DOHMH USE:

MS
 504
 IEP
 SC/SA

<u>Physician's Order</u>	<i>Order for Administration in School</i>	<i>Instructions in case of lack of improvement or adverse reaction</i>	<i>Choose all that are appropriate</i>
<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. Any alterations to this order must be re-written in Box #2 below.</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"/> Student may carry medication and may self-administer. (PARENT MUST INITIAL REVERSE SIDE.)</p> <p><input type="checkbox"/> Store medication in medical room and student to self-administer under observation.</p> <p><input type="checkbox"/> Store medication in medical room and nurse to administer.</p>
<p>2. Diagnosis _____</p> <p>_____</p> <p>Medication/Preparation/Concentration</p> <p>_____</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"/> Student may carry medication (includes epi pen and MDI) and may self-administer. (PARENT MUST INITIAL REVERSE SIDE.) NOT FOR CONTROLLED SUBSTANCES.</p> <p><input type="checkbox"/> Store medication in medical room and student to self-administer under observation.</p> <p><input type="checkbox"/> Store medication in medical room and nurse to administer.</p>
<p>3. Diagnosis _____</p> <p>_____</p> <p>Medication/Preparation/Concentration</p> <p>_____</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"/> Student may carry medication (includes epi pen and MDI) and may self-administer. (PARENT MUST INITIAL REVERSE SIDE.) NOT FOR CONTROLLED SUBSTANCES.</p> <p><input type="checkbox"/> Store medication in medical room and student to self-administer under observation.</p> <p><input type="checkbox"/> Store medication in medical room and nurse to administer.</p>

<p>List medication(s) student is taking at home and at what time:</p> <p>_____</p> <p>_____</p> <p>_____</p>	Physician's Name		Physician's Signature		<p>FOR DOHMH USE: Revisions per DOHMH</p> <p>_____</p> <p>_____</p> <p>_____</p>
	Physician/Clinic Address				
	Physician/Clinic Tel. No.	Physician/Clinic Fax No.	NYS Registration No.	Date	

OMISSIONS IN PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

ADMINISTRATION OF MEDICATION: PARENT/GUARDIAN'S CONSENT, AUTHORIZATION AND RELEASE
2005-2006

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary means of administration of such medication, in accordance with the attached instructions of my child's physician. I understand that the medication is to be furnished by me in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I further understand that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this Authorization is only valid until the earlier of: (1) **June 30, 2006** (This prescription may be extended through August if the student is attending a Department of Education sponsored summer program); or (2) such time that I deliver to the principal or his/her designee(s) and nurse a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed medication. By submitting this Medication Form, I am requesting that my child be provided with specific health services by the New York City Department of Education (the "Department") including the New York City Department of Health and Mental Hygiene (DOHMH) through the Office of School Health. I have provided the full and complete information and instructions regarding the provision of the above-requested health service(s) in this Medication Form. I understand that the Department, its agents, and its employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information and instructions that I have provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that I have provided in this Medication Form. I understand that it is my responsibility to provide the medication that has been prescribed for my child. I further understand that the Department and its agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by the Department of Education to provide the services requested, but, rather, my request, consent, authorization and release for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department of Education, its employees, and agents, to consult with and to obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child. I also authorize the principal, his/her designee(s) and school nurse to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph if applicable (for example, for use of an Epi-Pen, asthma inhaler and other medications):

_____ I hereby certify that my child has been fully instructed in and is proficient in the self-administration of the above-prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize the Department of Education, DOHMH, its agents and employees; including the principal, his/her designee(s), school nurse and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self carry and self administer in a responsible manner with the school. In addition, I agree to provide "back up" medication in a clearly labeled bottle to be kept in the medical room in the event my child does not have sufficient medication to self administer.

Please Print Parent/Guardian's Name & Address Below:

Parent/Guardian's Signature

Date Signed

Daytime Telephone No.

Home Telephone No.

(DO NOT WRITE BELOW - FOR DOE AND DOHMH ONLY)

Student's Name: _____

OSIS No: _____

Received by: _____
Name Date

Reviewed by: _____
Name Date

Referred to School 504 Coordinator Yes No

Self-Administers/Self-Carries: Yes No

Services provided by: Nurse DOHMH Public Health Adv.

School Based Health Center DOE School Staff

Signature and Title: _____
(RN OR MD)

(Date school notified and form forwarded to DOE Liaison)

Student's Name: Last: _____ First: _____ Middle: _____
Male: _____ Female: _____ D.O.B: _____ I.D. #: _____
Borough: _____ Region: _____ School: _____ Grade: _____ Class: _____
School Address: _____ Zip Code: _____

Physician's Statement for Requested Educational Services (if applicable):

- 1. Describe the nature of the concern: _____

- 2. Medical Diagnosis/Disability: _____

- 3. Describe how the disability affects the student's educational performance: _____

- 4. List/describe the educational service(s) that are being requested: _____

Physician's Name (Print)	Physician's Signature
Physician/Clinic's Address	NYS Registration No. Date Signed
Zip Code	Physician/Clinic's Telephone No. Physician/Clinic's Fax No.

Parent's Statement for Requested Educational Services:

- 1. Describe the nature of the concern: _____

- 2. Describe how the disability affects the student's educational performance: _____

- 3. List/describe the educational service(s) that are being requested: _____

If it is determined that educational services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school. This plan must be reviewed annually.

By submitting this Request for Educational Services, I am requesting that my child be provided with specific educational service(s) by the New York City Department of Education (the "Department"). I have provided the full and complete information regarding this request for educational service(s) in this form. I understand that the Department, its agents, and its employees involved in the provision of the above-requested educational service(s) are relying on the accuracy of the information that I have provided in this form to determine whether and to what extent my child will be provided with educational services.

Please Print Parent/Guardian's Name & Address Below:

Parent/Guardian's Signature	_____
Date Signed	_____
Daytime Telephone No.	_____

REQUEST FOR EDUCATIONAL SERVICES
2005- 2006

DO NOT WRITE BELOW
(FOR NYC DEPARTMENT OF EDUCATION USE ONLY)

Student's Name: _____

OSIS No: _____

Reviewed by: _____
Name (Please Print)

_____ Title Date

Request for Educational Service(s)

Approved _____

Denied _____

Referred for Further Review _____

Reason Request Approved or Denied:

Referred to CSE _____

Referred to 504 Coordinator _____

Date of Referral _____

Date of Referral _____

Signature

Date