

MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION) FORM Provider

Treatment Order Form | Office of School Health | School Year 2025-2026

 Attach
studentphoto here Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

Sex: Male Female OSIS Number: _____ Grade: _____ Class: _____ DOE District: _____

School (include ATSDBN/name, address, and borough): _____

HEALTHCARE PRACTITIONERS COMPLETE BELOW**ONE ORDER PER FORM** (make copies of this form for additional orders). Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization.

<input type="checkbox"/> Blood Pressure Monitoring	<input type="checkbox"/> Feeding Tube replacement if dislodged - specify in #5	<input type="checkbox"/> Trach Care: Trach. Size _____
<input type="checkbox"/> Chest Clapping/Percussion	<input type="checkbox"/> Oral / Pharyngeal Suctioning: Cath Size _____ Fr.	<input type="checkbox"/> Trach Replacement - specify in #5
<input type="checkbox"/> Clean Intermittent Catheterization: Cath Size _____ Fr.	<input type="checkbox"/> Ostomy Care	<input type="checkbox"/> Trach suctioning: Cath Size _____ Fr
<input type="checkbox"/> Central Line/PICC Line	<input type="checkbox"/> Oxygen Administration - specify in #1, including pulse oximetry	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dressing Change	<input type="checkbox"/> Postural Drainage	
<input type="checkbox"/> Feeding: Cath Size _____ Fr.	<input type="checkbox"/> Pulse Oximetry - specify in #1	
<input type="checkbox"/> Nasogastric <input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube		
<input type="checkbox"/> Bolus <input type="checkbox"/> Pump <input type="checkbox"/> Gravity <input type="checkbox"/> Spec./Non-Standard*		

Student will also require treatment: during transport on school-sponsored trips during afterschool programs**Student Skill Level** (Select the most appropriate option):

Nurse-Dependent Student: nurse must administer treatment
 Supervised Student: student self-treats under adult supervision
 Independent Student: student is self-carry/self-treat (initial below)

_____ I attest student demonstrated the ability to self-administer the prescribed treatment effectively
 Practitioner's initials during school, field trips, and school-sponsored events

Diagnosis: _____

Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS)Diagnosis is self- limited: Yes No _____. _____. _____. _____. _____. _____. _____**1. Treatment required in school:**

Feeding: Formula Name: _____ Concentration: _____
 Route: _____ Amount: _____ Rate: _____ Duration: _____ Frequency/specific time(s) of administration: _____

*Per the New York State Education Department, nurses are not permitted to administer premixed medications and feedings. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.

Flush with _____ mL _____ Before feeding After feeding

Oxygen Administration: Amount (L): _____ Route: _____ Frequency/specific time(s) of administration: _____
 prn O2 Sat < _____ % Specify signs & symptoms: _____

Other Treatment: Treatment Name: _____ Route: _____ Frequency/specific time(s) of administration: _____
 Specify signs & symptoms: _____

 Additional Instructions or Treatment:**2. Conditions under which treatment should not be provided:****3. Possible side effects/adverse reactions to treatment:****4. Emergency Treatment:** Provide specific instructions for clinical personnel (if present) in case of emergency or adverse reactions, including dislodgement or blockage of tracheostomy or feeding tube:**5. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:****6. Date(s) when treatment should be: Initiated: _____ Terminated: _____****Health Care Practitioner**Last Name (Print): _____ First Name (Print): _____ Please check one: MD DO NP PA

Signature: _____ Date: _____ NYS License # (Required): _____ NPI #: _____

Address: _____ E-mail address: _____

Tel: _____ Fax: _____ Cell Phone: _____

MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment Order Form | Office of School Health | School Year 2025–2026

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

PARENT/GUARDIAN READ, COMPLETE, AND SIGN: BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

- I consent to my child's medical supplies, equipment and prescribed treatments being stored and given at school based on directions from my child's health care practitioner.
- I understand that:
 - I must give the school nurse/school based health center (SBHC) provider my child's medical supplies, equipment and treatments.
 - All supplies I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired supplies for my child's use during school days.**
 - Supplies, equipment and treatments should be labeled with my child's name and date of birth.
 - I must **immediately** tell the school nurse/SBHC provider about any change in my child's treatments or the health care practitioner's instructions.
 - The Office of School Health (OSH) 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 form, I authorize OSH to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
 - The treatment instructions/orders on this form expire at the end of my child's school year, which may include the summer session, or when I give the school nurse a new form (whichever is earlier). When this medication order expires, I will give my child's school nurse/SBHC provider a new MAF written by my child's health care practitioner.
 - This form represents my consent and request for the medical services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Section 504 Accommodation Plan. This plan will be completed by the school.
 - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication, or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

Per the New York State Education Department, nurses are not permitted to administer premixed medications and feedings. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.

FOR SELF-TREATMENT (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can perform treatments on his or her own. I consent to my child carrying, storing and giving him or herself, the treatments prescribed on this form in school and on trips. I am responsible for giving my child these supplies and equipment labeled as described above. I am also responsible for monitoring my child's treatments, and for all results of my child's self-treatment in school. The school nurse/SBHC provider will confirm my child's ability to perform treatments on his/her own. I also agree to give the school clearly labeled "back up" equipment or supplies in the event that my child is unable to self-treat.

Student Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

School/ATSDBN/Name: _____

Borough: _____ District: _____

Parent/Guardian's Email: _____ Parent/Guardian's Address: _____

Telephone Numbers: Daytime: _____ Home: _____ Cell Phone*: _____

Parent/Guardian's Name: _____ Parent/Guardian's Signature: _____

Date Signed: _____

Alternate Emergency Contact:

Name: _____ Relationship to Student: _____ Contact Number: _____

FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

OSIS Number: _____

Received by: Name: _____ Date: _____ Reviewed by: _____ Date: _____

504 IEP Other 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 as per OSH contact with prescribing health care practitioner: Clarified Modified