



过敏/过敏反应症药物施用表

提供者治疗要求表 | 学校健康办公室 | 2025-2026 学年
请交还给学校护士/校内健康中心。6月1日之后递交的表格可能会对申请程序造成延误

学生姓氏: _____ 名字: _____ 中间名: _____ 出生日期: (月/日/年) _____
性别: ☐ 男 ☐ 女 学生身份号码(OSIS): _____ 年级: _____ 班级: _____
学校(包括名称、号码、地址和行政区): _____ 教育局学区: _____

健康护理人员填写以下部分 / HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergies:

History of asthma? ☐ Yes (If yes, student has an increased risk for a severe reaction; complete the Asthma MAF for this student) ☐ No

Does this student have the ability to: Self-manage (See 'Student Skill Level' below) ☐ Yes ☐ No
Recognize signs of allergic reactions ☐ Yes ☐ No
Recognize and avoid allergens independently ☐ Yes ☐ No

Select In-School Medications

SEVERE ALLERGIC REACTION

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

Weight: _____ kg

Injectable (IM) ☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg

Intranasal ☐ 1 mg ☐ 2 mg

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

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

☐ 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 and call 911.

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/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: _____

MILD ALLERGIC REACTION

A. Give for any of the following sign and symptoms • few hives • itchy mouth/nose/skin • mild nausea

• Name: _____ Preparation/Concentration: _____ Dose: _____ PO ☐ Q4 hours ☐ Q6 hours ☐ Q24 hours pm

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: _____

OTHER MEDICATION

• Give Name: _____ Preparation/Concentration: _____ Dose: _____ PO Q _____ hours pm

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

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

Rev 3/25

家长必须在第2页签名 / PARENTS MUST SIGN PAGE 2 →

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家长/监护人：通读、填写并签名。我在下面签名，表示我同意如下：

- 我同意，学校保存我子女的医药并根据我子女的保健专业人员的说明给药。我也同意，我子女的医药所需的任何器材都在学校里储存和使用。
- 我理解：
 - 我必须把我子女的医药和器材交给学校护士/校内健康中心（SBHC）提供者。我将尽量给学校有伸缩针头的肾上腺素注射器（epinephrine pens with retractable needles）。
 - 我给予学校的所有处方和非处方药物都必须是新的、未曾开封过并装在其原封瓶子或盒子里。我将给学校提供我子女在上学日内需使用的当前、未过期的医药用品。
 - 处方药物必须在其盒子或瓶子上有原装药房标签。标签必须包括：1) 我子女的姓名；2) 药房名称和电话号码；3) 我子女的保健专业人员的名称；4) 日期；5) 重配次数；6) 药物名称；7) 剂量；8) 何时用药；9) 如何用药；10) 任何其他说明。
 - 我谨此证明/确认，我已咨询我子女的保健专业人员，并且我同意学校健康办公室在万一我子女没有哮喘药物或肾上腺素药物之际可以给我子女施用储存的药物。
 - 如果我子女的药物发生任何变化或者保健专业人员的说明有任何变化，我必须立即告知学校护士/ SBHC提供者。
 - 涉及到给我子女提供上述健康服务的学校健康办公室（OSH）及其代理人员依赖于本表资讯的精确度。
 - 我在这一「药物施用表」（Medication Administration Form, 简称MAF）上签名，表示授权学校健康办公室（Office of School Health, 简称OSH）为我子女提供健康服务。这些服务可以包括（但不限于）由一名OSH办公室保健专业人员或护士所执行的临床评估或体检。
 - 这份MAF表的医疗执行手续的过期时间是我子女的学年结束（这可能包括暑期班）或者当我交给学校护士/ SBHC提供者一份新的MAF（取两者中较早的那个时间）。当这份医疗手续执行要求过期时,我将交给我子女的学校护士/ SBHC提供者一份新的由我子女的保健专业人员出具的MAF。
 - 这份表格代表我对本表所说明的过敏服务的同意和要求，并可以直接发送给学校健康办公室（OSH）。如果OSH决定提供这些服务，我子女可能还需要一份「第504款特别照顾计划」（Section 504 Accommodation Plan）。这份计划将由学校填写。
 - 为着给我子女提供护理或治疗的目的，OSH可以获取该办公室认为有关我子女的医疗状况、药物和治疗而需要的任何其他资讯。OSH可以向任何为我子女提供健康服务的保健专业人员、护士或药剂师索取该资讯。

注：如果您决定使用储存的药物，则您必须在您子女参加学校外出参观的日子以及/或者课后计划时让子女带上epinephrine、哮喘吸入器以及其他获准的药物，以备您子女使用。储存的药物只是由OSH员工在学校使用

自己用药（仅适用于能自己独立用药的学生）：

- 我证明/确认，我子女已得到完全的训练并能够自行用药。我同意，我子女在学校里以及在参加学校旅行时自己携带、储存本表所开具的药物并将自己用药。我负责根据上述说明把瓶子或盒子里的药物交给我子女。我也负责监督我子女在学校里的药物使用情况及其对这一药物使用所导致的任何后果。学校护士/ SBHC提供者将确认我子女拥有携带和自行用药的能力。我也同意交给学校「备用」药物（装在清楚地标示的盒子或瓶子里）。
- 我同意，如果我子女临时不能携带或自行用药，学校护士或经过训练的学校员工可以给我子女施用肾上腺素。

学生姓氏：_____ 名字：_____ 中间名：_____ 出生日期：(月/日/年)：_____
学校（ATS DBN/名称）：_____ 行政区：_____ 学区：_____
家长/监护人姓名（用英文清楚书写）：_____ 家长/监护人电子邮箱：_____
家长/监护人签名：_____ 签名日期：_____
家长/监护人地址：_____
家长 / 监护人手机号码：_____ 其他电话 _____
其他紧急联络人姓名/关系：_____
其他紧急联络人电话：_____

仅供学校健康办公室（OSH）工作人员填写 / For Office of School Health (OSH) Use Only

OSIS #: _____ Received by – Name: _____ Date: _____
☐ 504 ☐ IEP ☐ Other: _____ Reviewed by – Name: _____ Date: _____
Referred to School 504 Counselor: ☐ 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 Office of School Health after consultation with prescribing practitioner: ☐ Clarified ☐ Modified