



ALLERGIYA/ANAFILAKSIYAGA QARSHI DORINI QO'LLASH SHAKLI

2025–2026 o'quv yili uchun sog'liqni saqlash provayderlaridan dorilarga ko'rsatma shakli

Ilтимos, maktab hamshirasi/maktab sog'liqni saqlash markaziga murojaat qiling.

1 iyundan keyin topshirilgan arizalarni ko'rib chiqish yangi o'quv yiliga davom etishi mumkin.

O'quvchining familiyasi: _____ Ismi: _____ O'rta initials: _____ Tug'ilgan sana: _____
Jinsi: ☐ Erkak ☐ Ayol OSIS #: _____ Bosqich: _____ Sini: _____
Maktab (nomini, telefon raqamini, manzilini va tumanini ko'rsating): _____ DOE Okrug: _____

AMALIYOT SHIFOKORLARI QUYIDAGILARNI TO'LDIRADI / 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

OTA-ONALAR 2-SAHIFAGA IMZO CHEKISHLARI KERAK →

ALLERGIYA/ANAFILAKSIYAGA QARSHI DORINI QO'LLASH SHAKLI

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Itimos, maktab hamshirasi/maktab sog'liqni saqlash markaziga murojaat qiling. 1 iyundan keyin topshirilgan arizalarni ko'rib chiqish yangi o'quv yiliga davom etishi mumkin.

OTA-ONA/VASIY: O'QIDIM, BAJARDIM, VA IMZO CHEKDIM. IMZO CHEKISH ORQALI MEN QUYIDAGILARGA ROZILIK BILDIRAMAN:

- Farzandimning shifokorining ko'rsatmalariga muvofiq maktabda farzandimga dorilarni saqlash va tarqatishga rozilik beraman. Shuningdek, men farzandimning dorilari uchun zarur bo'lgan har qanday jihozlarni maktabda saqlash va ishlatisishiga
- Men shuni tushunamanki:**
 - Men farzandimning dorilari va jihozlarini maktab hamshirasi/maktabdagi sog'liqni saqlash markazi (SBHC) provayderiga taqdim etishim kerak. Men maktab o'quvchilariga tortiladigan ignalari bo'lgan adrenalinni ruchkalarni berishga harakat qilaman.
 - Maktabda beriladigan barcha retsept va retseptsiz dorilar yangi, ochilmagan va asl qadog'ida bo'lishi kerak. Farzandim maktab kunlarida foydalanishi uchun maktabni joriy, muddati o'tmagan dorilar bilan ta'minlayman.**
 - Retsept bo'yicha dori qadog'i yoki flakoni dorixonaning asl yorlig'iga ega bo'lishi kerak. Yorliqda quyidagilar ko'rsatilishi kerak: 1) farzandimning ismi, 2) dorixonasi nomi va telefon raqami, 3) farzandim shifokorining ismi, 4) sana, 5) qayta to'ldirish soni, 6) dori nomi, 7) dozasi, 8) dorini qachon qabul qilish kerakligi, 9) dorini qanday qabul qilish kerakligi va 10) boshqa ko'rsatmalar.
 - Farzandimning shifokori bilan maslahatlashganimni tasdiqlayman va agar farzandimda astma yoki epinefrin dorilari bo'lmasa, maktab sog'liqni saqlash boshqarmasi (OSH) farzandimni dori bilan ta'minlashga rozilik beraman.
 - Farzandimning dorilari yoki sog'liqni saqlash provayderi ko'rsatmalaridagi har qanday o'zgarishlar haqida maktab hamshirasini/sog'liqni saqlash provayderini darhol xabardor qilishim kerak
 - OSH va uning farzandimga yuqoridagi tibbiy xizmatlarni ko'rsatishda ishtirok etgan xodimlari ushbu shakldagi ma'lumotlarning to'g'riligiga tayanadi
 - Ushbu dorilarni qabul qilish uchun ruxsatnoma shaklini (MAF) imzolash orqali men OSH farzandimga tibbiy xizmatlar ko'rsatishga ruxsat beraman. Ushbu xizmatlar OSH sog'liqni saqlash amaliyot shifokori yoki hamshira tomonidan klinik baholash yoki fizik tekshiruvni o'z ichiga olishi mumkin, lekin ular bilan cheklanmaydi.
 - Ushbu MAF bo'yicha dorilarga ko'rsatma berish muddati farzandimning o'quv yilining oxirida tugaydi, yozgi sessiyani o'z ichiga olishi mumkin yoki men maktab hamshirasi/SBHC provayderiga yangi MAF ni berganimda tugaydi, bu qaysi holat birinchi bo'lishiga bog'liq. Ushbu dori ko'rsatmasining amal qilish muddati tugagach, men maktab hamshirasiga/SBHC amaliyot shifokori farzandimning shifokori tomonidan yozilgan yangi ruxsatnomani beraman
 - Ushbu shakl mening roziligim va ushbu shaklda tasvirlangan qandoli allergiyani davolash xizmatlarini olishga bo'lgan so'rovimni tashkil etadi va uni to'g'ridan-to'g'ri maktabga topshirish mumkin. Bu OSH tomonidan so'ralgan xizmatlarga rozilik hisoblanmaydi. Agar OSH ushbu xizmatlarni taqdim etishga rozi bo'lsa, farzandim Bo'lim 504 yashash rejasiga muhtoj bo'lishi mumkin. Ushbu reja maktab tomonidan tuziladi.
 - Farzandimga g'amxo'rlik yoki davolanishni ta'minlash uchun OSH farzandimning sog'lig'i, dorilari yoki davolanishi haqida zarur deb hisoblagan boshqa ma'lumotlarni olishi mumkin. OSH bu ma'lumotni farzandimga tibbiy yordam ko'rsatgan har qanday amaliyot shifokori, hamshira yoki farmatsevtidan olishi mumkin

ESLATMA: Agar shoshilinch dori vositalaridan foydalanishni tanlasangiz, farzandingizning maktab safari va/yoki darsdan tashqari mashg'ulotlari uchun epinefrin, astma ingalyatori va boshqa tasdiqlangan dorilarni olib kelishingiz kerak. Shoshilinch dori vositalaridan faqat maktabda mehnatni muhofaza qilish va sog'liqni saqlash bo'yicha xodimlar foydalanishi mumkin.

DORILARNI MUSTAQIL QABUL QILISH UCHUN (FAQAT MUSTAQIL O'QUVCHILAR):

- Farzandim barcha tayyorgarlikdan o'tganini va mustaqil ravishda dorilarni qabul qilish olishini tasdiqlayman. Men farzandimning maktabda va sayohat paytida ushbu shaklda ko'rsatilgan dorilarni olib yurishiga, saqlashiga va mustaqil foydalanishiga rozilik beraman. Men yuqorida aytib o'tilganidek, ushbu dorilarni farzandimga flakon yoki qutilarda yuborish uchun javobgarman. Shuningdek, men farzandimning dori vositalaridan foydalanishini nazorat qilish va farzandimning maktabda ushbu dori vositasidan foydalanishining barcha natijalari uchun javobgarman. Maktab hamshirasi yoki SBHC tibbiy yordam ko'rsatuvchi provayderlari mening farzandim dorilarni olib yurishi va mustaqil qabul qilishi mumkinligini tasdiqlaydi. Shuningdek, men maktabga tushunarli yorliqli qutilar yoki shishalarda qo'shimcha dorilarni taqdim etishga ruxsat berishga roziman
- Agar farzandim vaqtincha dorilarni o'zri bilan olib yurolmasa va uni o'zi qo'llay olmasa, maktab hamshirasi yoki malakali maktab xodimlariga farzandimga epinefrin yuborishga rozilik beraman.

O'quvchining familiyasi: _____ Ismi: _____ MI: _____ Tug'ilgan sanasi (k/o/y): _____
Maktab (ATS DBN/Nomi): _____ Shahar: _____ Okrug: _____
Ota-ona/vasiyning ismi (bosma harflarda): _____ Ota-ona/Vasiy elektron pochta manzili: _____
Ota-ona/Vasiyning imzosi: _____ Imzolangan sana: _____
Ota-ona/Vasiy manzili: _____
Ota-ona/Vasiy telefon raqami: _____ Boshqa raqam: _____
Boshqa shoshilinch kontakt/qarindoshi raqami: _____
Boshqa shoshilinch kontakt raqami: _____

Faqat Maktab salomatlik bo'limida (OSH) foydalanish uchun / 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