Attach student photo here

# ASTMAGA QARSHI DORILARNI QABUL QILISH SHAKLI

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

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

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

O'quvchining familiyasi: _____ Ismi: _____ O'rta initsiallari: _____ Tug'ilgan sanasi (k/o/y): _____

Jinsi: ☐ Erkak ☐ Ayol OSIS #: _____ Bosqich: _____ Sinfi: _____

Maktab (ATS DBN / nomini, telefon raqamini, manzilini va tumanini ko'rsating): _____ DOE Okrug: _____

## AMALIYOT SHIFOKORLARI QUYIDAGILARNI TO'LDIRADI / HEALTH CARE PRACTITIONERS COMPLETE BELOW

**Diagnosis**
☐ Asthma
☐ Other: _____

**Control** *(see NAEPP Guidelines)*
☐ Well Controlled
☐ Not Controlled / Poorly Controlled
☐ Unknown

**Severity** *(see NAEPP Guidelines)*
☐ Intermittent
☐ Mild Persistent
☐ Moderate Persistent
☐ Severe Persistent
☐ Unknown

**Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)**

| | | | | |
|---|---|---|---|---|
| History of near-death asthma requiring mechanical ventilation | ☐ Y | ☐ N | ☐ U | |
| History of life-threatening asthma (loss of consciousness or hypoxic seizure) | ☐ Y | ☐ N | ☐ U | |
| History of asthma-related PICU admissions (ever) | ☐ Y | ☐ N | ☐ U | |
| Received oral steroids within past 12 months | ☐ Y | ☐ N | ☐ U | _____ times last: _____ |
| History of asthma-related ER visits within past 12 months | ☐ Y | ☐ N | ☐ U | _____ times last: _____ |
| History of asthma-related hospitalizations within past 12 months | ☐ Y | ☐ N | ☐ U | _____ times last: _____ |
| History of food allergy or eczema, specify: _____ | ☐ Y | ☐ N | ☐ U | |
| Excessive Short Acting Beta Agonist (SABA) use (daily or > 2 times a week)? | ☐ Y | ☐ N | ☐ U | |

### Home Medications (include over the counter) ☐ None

☐ Reliever: _____ ☐ Controller: _____ ☐ Other: _____

### 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: _____

### Quick Relief In-School Medication

***Individual spacers are provided by the school. Schools will only provide Albuterol MDI and Fluticasone 110 ucg***

**Emergency Plan: If in Respiratory Distress: call 911 and give albuterol 6 puffs: may repeat Q 20 minutes until EMS arrives!**

**Standard Albuterol Order**: *Albuterol: Give 2 puffs Q4 prn cough, wheezing, difficulty breathing, chest tightness or shortness of breath*
*Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE.*

☐ **Pre-exercise**: Name:_____ Dose: _____puffs/ _____AMP 15-20 mins before exercise.

☐ **URI Symptoms/Recent Asthma Flare:**
Name:_____Dose: _____puffs/ _____AMP q _____hrs for ____ days when directed by PCP

**Other Quick Relief Medication instead of Standard Albuterol Order: SMART/MART (ginasthma.org)**
**Administer medication for respiratory symptoms: cough, wheezing, difficulty breathing, chest tightness, or shortness of breath; if not symptom free in 20 minutes, may repeat ONCE.**
**The Standard Albuterol Order will be implemented if medication prescribed below is unavailable.**

☐ Budesonide/formoterol **(provided by parent)**: Strength:_____ Dose: ☐ 1 puff ☐ 2 puffs every 4 hours PRN respiratory symptoms
☐ Albuterol with ICS:Albuterol 2 puffs plus Fluticasone 110 ucg 1 puff every 4 hours PRN respiratory symptoms.
☐ Albuterol with ICS: Albuterol: 2 puffs plus Fluticasone 110 ucg ____ puffs every 4 hours PRN respiratory symptoms.

Albuterol____ puffs + ICS **(provided by parent)** Name: _____ Strength _____ : ____ puffs every 4 hours PRN respiratory symptom

**Special Instructions:** _____

### Controller Medications for In-School Administration (Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ Fluticasone [*Only Fluticasone® 110 mcg MDI is provided by school for shared usage*] ☐ Stock ☐ Parent Provided
Standing Daily Dose: ___ puff(s) ☐ one OR ☐ two time(s) a day Time: _____ AM and _____ PM

☐ Symbicort (provided by parent). Standing Daily Dose: ___ puff(s) ☐ one OR ☐ two time(s) a day Time: _____ AM and _____ PM
Special Instructions: _____

☐ Other ICS (provided by parent) Standing Daily Dose:
Name: _____ Strength: _____ Dose: ___ Route: _____ Frequency: ☐ one or ☐ two time(s) a day Time: _____ AM and _____ PM

### Health Care Practitioner

Last Name (Print): _____ First Name (Print): _____ Please check one: ☐ MD ☐ DO ☐ NP ☐ PA

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

Completed by Emergency Department Medical Practitioner: ☐ Yes ☐ No (ED Medical Practitioners will not be contacted by OSH/SBHC Staff)

Address: _____ Email address: _____

Telephone: _____ FAX: _____ Cell Phone: _____

**CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.**

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS Rev 3/25
FORMS CANNOT BE COMPLETED BY A RESIDENT

**OTA-ONALAR 2-SAHIFAGA IMZO CHEKISHLARI KERAK ➔**

# ASTMAGA QARSHI DORILARNI QABUL QILISH SHAKLI

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

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

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

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

1. 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 ishlatilishiga
2. **Men shuni tushunamanki:**
   - Men farzandimning dorilari va jihozlarini, jumladan, albuterol bo'lmagan ingalyatorlarini maktab hamshirasi/maktabdagi sog'liqni saqlash markazi (SBHC) provayderiga taqdim etishim kerak.
   - **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) dorixona 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 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 qabulining amal qilish muddati tugagach, men farzandimning maktab hamshirasiga/SBHC provayderiga farzandimning birlamchi tibbiy yordam shifokori tomonidan yozilgan yangi dorilarga ruxsat berish shaklini taqdim etaman. Agar bu bajarilmasa, men maktab hamshirasi/SBHC ga farzandimni OSH provayderi tekshirishini istamasligim haqida xat bermagunimcha, farzandimni OSH provayderi tekshirishi mumkin. OSH provayderi mening farzandimning astma belgilari va buyurilgan astma dorilariga javobini baholashi mumkin. OSH provayderi dori qabuli o'zgarmasligi yoki o'zgartirilishi kerakligi haqida qaror qabul qilishi mumkin. Mening farzandim OSH orqali sog'liqni saqlash xizmatlarini olishda davom etishi uchun OSH provayderi yangi MAFni to'ldirishi mumkin. Mening shifokorim yoki OSH provayderim kelajakdagi astma MAFlarini to'ldirish uchun mening imzoyimga muhtoj emas. Agar OSH sog'liqni saqlash mutaxassisi farzandim uchun yangi MAF chiqarsa, u men va farzandimning sog'liqni saqlash mutaxassisiga xabar berishga harakat qiladi.
   - Ushbu shakl mening roziligim va ushbu shaklda tasvirlangan qandli astmani 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 farmatsevtdan 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

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 ☐ OSH Asthma Case Manager (for supervised students only)

Signature and Title (RN or MD/DO/NP): _____

Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Clarified ☐ Modified