



普通药物施用表

本表不应用于糖尿病、癫痫、哮喘或过敏药物

提供者药物要求表 | 学校健康办公室 | 2025-2026 学年

请交还给学校护士。6月1日之后递交的表格可能会对新学年的申请程序造成延误

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

1. Diagnosis: _____ **ICD-10 Code:** ☐ _____ . _____
Medication (Generic and/or Brand Name): _____
Preparation/Concentration: _____ Dose: _____ mg Route: _____
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 - *Initial below for Independent (not allowed for controlled substances)
☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events. Practitioner's Initials: _____
In School Instructions
☐ Standing daily dose – at _____ and _____ and/or
☐ PRN – specify signs, symptoms, or situations: _____
☐ Time interval: _____ minutes or _____ hours as needed.
☐ If no improvement, repeat in _____ minutes or _____ hours for a maximum of _____ times.
Conditions under which medication should not be given: _____

2. Diagnosis: _____ **ICD-10 Code:** ☐ _____ . _____
Medication (Generic and/or Brand Name): _____
Preparation/Concentration: _____ Dose: _____ mg Route: _____
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 - *Initial below for Independent (not allowed for controlled substances)
☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events. Practitioner's Initials: _____
In School Instructions
☐ Standing daily dose – at _____ and _____ and/or
☐ PRN – specify signs, symptoms, or situations: _____
☐ Time interval: _____ minutes or _____ hours as needed.
☐ If no improvement, repeat in _____ minutes or _____ hours for a maximum of _____ times.
Conditions under which medication should not be given: _____

3. Diagnosis: _____ **ICD-10 Code:** ☐ _____ . _____
Medication (Generic and/or Brand Name): _____
Preparation/Concentration: _____ Dose: _____ mg Route: _____
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 - *Initial below for Independent (not allowed for controlled substances)
☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events. Practitioner's Initials: _____
In School Instructions
☐ Standing daily dose – at _____ and _____ and/or
☐ PRN – specify signs, symptoms, or situations: _____
☐ Time interval: _____ minutes or _____ hours as needed.
☐ If no improvement, repeat in _____ minutes or _____ hours for a maximum of _____ times.
Conditions under which medication should not be given: _____

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

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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。
 - 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姓名, 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 以及 10)任何其他说明。
 - 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。
 - 学生不得携带或自我施用受管制的药物。
 - 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」(MAF)上签名,则学校健康办公室(OSH)可以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医疗服务的同意和要求,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「学生特别照顾计划」(Student 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:最好是您在学校外出参观的日子和在校外进行学校活动时给子女带上药物和器材。

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产生的任何结果。学校护士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)。

学生姓名: _____ 名字: _____ 中间名首字母: _____ 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: _____
电话号码: 日间: _____ 住宅: _____ 手机: _____
其他紧急联系人: _____
姓名: _____ 与学生的关系: _____ 电话号码: _____

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 OSH contact with prescribing health care practitioner: ☐ Clarified ☐ Modified

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