Attach student photo here

UMUMIY DORILARNI QABUL QILISH SHAKLI

USHBU SHAKL DIABET, TALVASA, ASTMA YOKI ALLERGIYA UCHUN ISHLATILISHI KERAK **EMAS**

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

AMALIYOT SHIFOKORLARI QUYIDAGILARNI TO'LDIRADI/ 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 Rev 3/25

FORMS CANNOT BE COMPLETED BY A RESIDENT **OTA-ONALAR 2-SAHIFAGA IMZO CHEKISHLARI KERAK ➔**

UMUMIY DORILARNI QABUL QILISH SHAKLI

USHBU SHAKL DIABET, TALVASA, ASTMA YOKI ALLERGIYA UCHUN ISHLATILISHI KERAK **EMAS**

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 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 dorilari yoki sog'liqni saqlash provayderi ko'rsatmalaridagi har qanday o'zgarishlar haqida maktab hamshirasini/sog'liqni saqlash provayderini **darhol** xabardor qilishim kerak
   - **Hech bir o'quvchiga noqonuniy moddalarni olib yurish yoki boshqarishga ruxsat berilmaydi.**
   - Maktab sog'liqni saqlash bo'limi (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/amaliyot shifokoriga farzandimning shifokori tomonidan yozilgan yangi ruxsatnomani beraman.
   - Ushbu shakl mening roziligim va ushbu shaklda tasvirlangan dori 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: Farzandingiz uchun dorilar va jihozlarni maktab sayohati kuni va darsdan tashqari mashg'ulotlar uchun yuborish tavsiya etiladi.

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: _____

Telefon raqami: Kun vaqti: _____ Uy: _____ Uyali telefoni: _____

Muqobil shoshilinch kontakt:

Ism-sharif: _____ O'quvchiga qarindoshlik darajasi: _____ Telefon 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 OSH contact with prescribing health care practitioner: ☐ Clarified ☐ Modified

Rev 3/25