

學生照片
附此

GENERAL MEDICATION ADMINISTRATION FORM

本表不應用於糖尿病、癲癇、哮喘或過敏藥物

提供者藥物要求表 | 學校健康辦公室 | 2025-2026學年

請交還給學校護士。6月1日之後遞交的表格可能會對新學年的申請程序造成延誤

學生姓氏: _____ 名字: _____ 中間名: _____ 出生日期: (月/日/年) _____
性別: ☐ 男 ☐ 女 學生身份號碼(OSIS): _____ 年級: _____ 班級: _____
學校 (包括名稱、號碼、地址和行政區): _____ 教育局學區: _____

健康護理人員填寫以下部分 / 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

Rev 3/25

家長必須在第2頁簽名 / PARENTS MUST SIGN PAGE 2 →

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家長/監護人：通讀、填寫並簽名。我在下面簽名，表示我同意如下：

- 我同意，學校保存我子女的醫藥並根據我子女的保健專業人員的說明給藥。我也同意，我子女的醫藥所需的任何器材都在學校裏儲存和使用。
- 我理解：
 - 我必須把我子女的醫藥和器材交給學校護士。
 - 我給予學校的所有處方和非處方藥物都必須是新的、未曾開封過並裝在其原封瓶子或盒子裏。我將給學校提供我子女在上學日內需使用的當前、未過期的醫藥用品。
 - 處方藥物必須在其盒子或瓶子上有**原裝藥房**標籤。標籤必須包括：1) 我子女的姓名，2) 藥房名稱和電話號碼，3) 我子女的保健專業人員姓名，4) 日期，5) 重配次數，6) 藥物名稱，7) 劑量，8) 何時用藥，9) 如何用藥 以及 10) 任何其他說明。
 - 如果我子女的藥物發生任何變化或者保健專業人員的說明有任何變化，我必須**立即**告知學校護士。
 - 學生不得攜帶或自我施用受管制的藥物。**
 - 涉及到給我子女提供上述健康服務的學校健康辦公室（OSH）及其代理人員依賴於本表資訊的精確度。
 - 我在這一「藥物施用表」（MAF）上簽名，則學校健康辦公室（OSH）可以為我子女提供健康服務。這些服務可以包括（但不限於）由一名OSH辦公室保健專業人員或護士所執行的臨床評估或體檢。
 - 這份MAF表的醫療執行手續的過期時間是我子女的學年結束（這可能包括暑期班）或者當我交給學校護士一份新的MAF（取兩者中較早的那個時間）。當這份醫療手續執行要求過期時，我將交給我子女的學校護士一份新的由我子女的保健專業人員出具的MAF。
 - 這份表格代表我對本表所說明的醫療服務的同意和要求，並可以直接發送給學校健康辦公室（OSH）。如果OSH決定提供這些服務，我子女可能還需要一份「學生特別照顧計劃」（Student Accommodation Plan）。這份計劃將由學校填寫。
 - 為著給我子女提供護理或治療的目的，OSH可以獲取該辦公室認為有關我子女的醫療狀況、藥物和治療而需要的任何其他資訊。OSH可以向任何為我子女提供健康服務的保健專業人員、護士或藥劑師索取該資訊。

註：最好是您在學校外出參觀的日子和在校外進行學校活動時給子女帶上藥物和器材。

自己用藥（僅適用於能自己獨立用藥的學生）：

- 我證明/確認，我子女已得到完全的訓練並能夠自行用藥。我同意，我子女在學校裏以及在參加學校旅行時自己攜帶、儲存本表所開具的藥物並將自己用藥。我負責根據上述說明把瓶子或盒子裏的藥物交給我子女。我也負責監督我子女在學校裏的藥物使用情況及其對這一藥物使用所產生的任何結果。學校護士將確認我子女擁有攜帶和自行用藥的能力。我也同意交給學校「備用」藥物（裝在清楚地標示的盒子或瓶子裏）。

學生姓氏: _____ 名字: _____ 中間名首字母: ____ 出生日期: (月/日/年) _____
學校 (ATS DBN/名稱): _____ 行政區: _____ 學區: _____
家長/監護人姓名 (用英文清楚書寫): _____ 家長/監護人電子郵件: _____
家長/監護人簽名: _____ 簽名日期: _____
家長/監護人地址: _____
電話號碼: _____ 日間: _____ 住宅: _____ 手機: _____
其他緊急聯絡人: _____
姓名: _____ 與學生的關係: _____ 電話號碼: _____

僅供學校健康辦公室（OSH）工作人員填寫 / 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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