



# 过敏/过敏反应的药物施用表

提供者医疗手续执行表 | 学校健康办公室 | 2026-2027 学年

请将其交回给学校护士/学校健康中心。6月1日之后递交的表格可能会对新一学年的申请程序造成延误。

学生姓氏: \_\_\_\_\_ 名字: \_\_\_\_\_ 中名首字母: \_\_\_\_\_ 出生日期: \_\_\_\_\_  
性别:  男  女 学生身份号码(OSIS): \_\_\_\_\_ 年级: \_\_\_\_\_ 班级: \_\_\_\_\_ 教育局学区: \_\_\_\_\_  
学校 (包括名称、号码、地址和行政区): \_\_\_\_\_

## 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 epinephrine for any of the following signs and symptoms:

- Shortness of breath, wheezing, or coughing
- Fainting or dizziness
- Lip or tongue swelling that bothers breathing
- Pale or bluish skin color
- Tight or hoarse throat
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Weak pulse
- Trouble breathing or swallowing
- Feeling of doom, confusion, altered consciousness or agitation
- Many hives or redness over body

Other signs and/or symptoms: \_\_\_\_\_

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, do not enter ranges)

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 (parent must supply medicine for use in medical room) Note: if more than one oral medication is prescribed, this will be given first

Give for any of the following sign and symptoms • few hives • itchy mouth/nose/skin • mild nausea

SELECT ONE:

- Cetirizine Preparation/Concentration: \_\_\_\_\_ Dose: \_\_\_\_\_ PO  Q24 hours pm
- Diphenhydramine Preparation/Concentration: \_\_\_\_\_ Dose: \_\_\_\_\_ PO  Q4 hours pm  Q6 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 ALLERGY MEDICATION: Give in addition to as alternative to the medication above

• 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: \_\_\_\_\_

医疗专业人员的信息不完整, 将导致医药手续执行的延误  
表格不能由驻院医生填写

2026年2月修订  
家长必须在第2页签名

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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：**

1. 我同意，学校保存我子女的医药并根据我子女的健康护理人员的说明给药。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。

### 2. 我理解：

- 我必须把我子女的医药和器材交给学校护士/学校健康中心（SBHC）。我将尽量给学校有伸缩针头的肾上腺素注射器（epinephrine pens with retractable needles）。
- 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期所需的当前、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) 我子女的健康护理人员姓名，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。
- 我谨此证明/确认，我已咨询我子女的健康护理人员，并且我同意学校健康办公室（OSH）在万一我子女没有哮喘药物或肾上腺素药物时可以给我子女施用储存的药物。
- 如果我子女的药物或者健康护理服务提供者的说明有任何变化，我必须**立即**告知学校护士/SBHC 提供者。
- 参与为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格信息的精确度。
- 我在这一“药物施用表”（MAF）上签名，则表明我授权学校健康办公室（OSH）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 办公室健康护理人员或护士所执行的临床评估或体检。
- 这份 MAF 表所嘱咐的药物用法在以下时间失效：我子女的学年结束时（这可能包括暑期班），或者在我交给学校护士/SBHC 服务提供者一份新的 MAF 时（以时间较早者为准）。当这份嘱咐的药物用法表失效时，我将交给子女的学校护士/SBHC 服务提供者一份新的由我子女的健康护理服务提供者出具的 MAF。
- 这份表格代表我同意并要求提供本表格内说明的过敏服务，并可以直接发送给学校健康办公室（OSH）。这并非 OSH 提供所要求的服务的协议。如果 OSH 决定提供这些服务，我子女可能还需要一份“504 特别照顾计划”（Section 504 Accommodation Plan）。这份计划将由学校填写。
- 为着我子女提供护理或治疗的目的，OSH 可以获取该办公室认为所需要的有关我子女的健康问题、药物和治疗相关的任何其他信息。OSH 可以向任何为我子女提供健康服务的健康护理人员、护士或药剂师索取该信息。

**请注意：在学校外出参观日和/或课后计划中，如果您决定使用储存的药物，您必须让子女随身带上肾上腺素、哮喘药物吸入器以及其他任何获准的药物。储存的药物仅由 OSH 工作人员在学校使用。**

### 自己用药（仅适用于能自己独立用药的学生）：

- 我证明/确认，我子女已得到充分的训练并能够自行用药。我同意，我的子女在学校里以及在学校外出活动时自己携带、储存并自己施用本表格上所开具的药物。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导致的任何后果。学校护士/SBHC 服务提供者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）。
- 我同意，如果我子女临时不能携带或自行用药，学校护士或经过训练的学校员工可以给我子女施用肾上腺素。

学生 姓氏：\_\_\_\_\_ 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：\_\_\_\_\_

家长 / 监护人手机号码：\_\_\_\_\_ 其他电话：\_\_\_\_\_

其他紧急联络人姓名/关系：\_\_\_\_\_

其他紧急联络人电话：\_\_\_\_\_

### For Office of School Health (OSH) Use Only（仅供工作人员填写）

OSIS Number: \_\_\_\_\_ Received by - Name: \_\_\_\_\_ Date: \_\_\_\_\_

504  IEP  Other: \_\_\_\_\_ Reviewed by - Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referred to School 504 Coordinator:  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