Attach student photo here

# ALLERGIYA/ANAFILAKSIYAGA QARSHI DORINI BERISH SHAKLI

Sog‘liqni saqlash provayderlaridan dori-darmonga buyurtma berish shakli | Maktab sog‘liqni saqlash idorasi | **2026–2027**-o‘quv yili

**Shaklni maktab hamshirasi/maktab qoshidagi sog‘liqni saqlash markaziga qaytaring. 1-iyundan keyin topshirilgan shakllar yangi o‘quv yili uchun ularni qayta ishlashni kechiktirishi mumkin.**

O‘quvchining familiyasi: _____ Ismi: _____ O'rta initsiali: _____ Tug‘ilgan sanasi: _____
Jinsi: ☐ Erkak ☐ Ayol OSIS #: _____ Sinfi: _____ Sinfi: _____ Ta’lim boshqarmasi okrugi: _____
Maktab (nomini, telefon raqamini, manzilini ko’rsating): _____

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

☐ 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: _____

SHIFOKORGA OID TO‘LIQ BO‘LMAGAN AXBOROT DORI-DARMONGA BUYURTMA BERISHNI KECHIKTIRADI SHAKLLARNI REZIDENT TO’LDIRISHI MUMKIN EMAS

Tahrir 2/26

**OTA-ONALAR 2-BETNI IMZOLASHI LOZIM**

# ALLERGIYA/ANAFILAKSIYAGA QARSHI DORINI BERISH SHAKLI

**2026-2027** 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, TO‘LDIRDIM 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. Men maktab o'quvchilariga tortiladigan ignalari bo'lgan adrenalinli ruchkalarni berishga harakat qilaman.
   - **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 yoki epinefrin 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
   - SBHC 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/SBHC provayderiga farzandimning shifokori tomonidan yozilgan yangi ruxsatnomani beraman.
   - Ushbu shakl mening roziligim va ushbu shaklda tasvirlangan qandli allergiyani 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 (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
- Agar farzandim vaqtincha dorilarni o'zri bilan olib yurolmasa va uni o'zi qo’llay olmasa, maktab hamshirasi yoki malakali maktab xodimlariga farzandimga epinefrin yuborishga rozilik beraman.

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**O‘quvchining** familiyasi: _____ Ism: _____ MI: ____ Tug‘ilgan sanasi (k/o/y): _____

**Maktab** (ATS DBN/nomi): _____ Tuman: _____ Tuman: _____

**Ota-ona/Vasiyning** ismi (bosma harflarda): _____ Ota-ona/Vasiy elektron pochta manzili: _____

**Ota-ona/Vasiyning** imzosi: _____ Imzolangan sana: _____

**Ota-ona/Vasiyning** manzili: _____

**Ota-ona/Vasiyning** telefon raqami: _____ Boshqa raqam: _____

**Boshqa shoshilinch kontaktning** ismi/qarindoshligi: _____

**Boshqa shoshilinch kontaktning** telefon raqami: _____

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**For Office of School Health (OSH) Use Only**

**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