ASTMAGA QARSHI DORILARNI QABUL QILISH 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 (ATS DBN / nomini, manzilini va tumanini ko'rsating): ______

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis ☐ Asthma ☐ Other: ______
Severity *(see NAEPP Guidelines* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Unknown
Control *(see NAEPP Guidelines)* ☐ Well Controlled ☐ Not Controlled / Poorly Controlled ☐ Unknown

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

☐ Y ☐ N ☐ U | History of life-threatening asthma (loss of consciousness, hypoxic seizure, or intubation)
☐ Y ☐ N ☐ U | History of asthma-related PICU admissions (ever)
☐ Y ☐ N ☐ U | Received oral steroids within past 12 months _____ times last: ______
☐ Y ☐ N ☐ U | History of asthma-related ER visits within past 12 months _____ times last: ______
☐ Y ☐ N ☐ U | History of asthma-related hospitalizations within past 12 months _____ times last: ______
☐ Y ☐ N ☐ U | History of food allergy or eczema, specify: ______
☐ Y ☐ N ☐ U | Excessive Short Acting Beta Agonist (SABA) use (daily or > 2 times a week)?

Home Medications (include over the counter) ☐ None

☐ Reliever: ☐ Albuterol ☐ Budesonide/formoterol ☐ Other: ______
☐ Controller: ☐ Albuterol ☐ Budesonide/formoterol ☐ Other: ______
☐ Other: ______

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: _________

Quick Relief In-School Medication

- **Emergency Plan: If in Respiratory Distress: call 911 and give albuterol 6 puffs: may repeat Q 20 minutes until EMS arrives!**
- ***Individual spacers are provided by the school. Schools will only provide Albuterol MDI and Fluticasone 110 ucg***

☑ **Standard Albuterol Order**: *2 puffs Q4 prn cough, wheezing, difficulty breathing, chest tightness or shortness of breath.*
Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE.

☐ **Pre-exercise**: ☐ Albuterol ☐ Budesonide/formoterol
Dose: __________ puffs/ _____ AMP ☐ 15-20 mins before exercise ☐ PRN ______
☐ **URI Symptoms/Recent Asthma Flare:** ☐ Albuterol ☐ Budesonide/formoterol
Dose: __________ puffs/ _____ AMP q _____ hrs prn symptoms for _____ days or as per PCP's Special Instructions/Other Orders below

Other Anti-inflammatory Reliever Medication instead of Standard Albuterol Order: SMART/MART (ginasthma.org): Administer medication for respiratory symptoms: cough, wheezing, difficulty breathing, chest tightness, or shortness of breath; if not symptom-free in 20 minutes, may repeat ONCE. The Standard Albuterol Order will be implemented if medication prescribed below is unavailable.

☐ Budesonide/formoterol **(provided by parent)**: Strength: __________ Dose: ☐ 1 puff ☐ 2 puffs every 4 hours PRN respiratory symptoms
☐ Albuterol with ICS: Albuterol: 2 puffs plus Fluticasone 110 mcg _____ puffs every 4 hours PRN respiratory symptoms.
☐ Albuterol _____ puffs + ICS **(provided by parent)** Name: ______
Strength: __________ Dose _____ puffs every 4 hours PRN respiratory symptoms
☐ Albuterol or other Quick-Relief Medication: Name: ______
Strength: __________ Dose _____ puffs/AMP: _____ every _____ hours PRN respiratory symptoms
Special Instructions/Other Orders: ______

Controller Medications for In-School Administration (Recommended for Persistent Asthma, per NAEPP Guidelines)

Stock Fluticasone 110 mcg will be used if prescribed medication below is not available.

☐ Fluticasone [*Only Fluticasone® 110 mcg MDI is provided by school for shared usage*] ☐ Stock ☐ Parent Provided
Standing Daily Dose: _____ puff(s) ☐ one OR ☐ two time(s) a day Time: _____ AM and _____ PM
☐ Budesonide/formoterol **(provided by parent)**. Standing Daily Dose: _____ puff(s) ☐ one OR ☐ two time(s) a day Time: _____ AM and _____ PM
Special Instructions: ______
☐ Other ICS **(provided by parent)** Standing Daily Dose: Name: ______
Strength __________ Dose _____ Route _____ Frequency: ☐ one OR ☐ two time(s) a day Time: _____ AM and _____ PM

Health Care Practitioner

Last Name (Print): ______ First Name (Print): ______ Please check one: ☐ MD ☐ DO ☐ NP ☐ PA
Signature: ______ Date: ______ NYS License # (Required): ______ NPI #: ______
Completed by Emergency Department Medical Practitioner: ☐ Yes ☐ No (ED Medical Practitioners will not be contacted by OSH/SBHC Staff)
Address: ______ Email address: ______
Telephone: ______ FAX: ______ Cell Phone: ______

CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

SHAKLLARNI REZIDENT TO'LDIRISHI MUMKIN EMAS — Tahrir 2/26
SHIFOKORGA OID TO'LIQ BO'LMAGAN AXBOROT DORI-DARMONGA BUYURTMA BERISHNI KECHIKTIRADI — **OTA-ONALAR 2-BETDA IMZOLASHI LOZIM**

ASTMAGA QARSHI DORILARNI QABUL QILISH SHAKLI

Astmaga oid sog‘liqni saqlash provayderlaridan dori-darmonga buyurtma berish | 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.

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 quyidagilarni tushunaman:
   - Men farzandimning dorilari va jihozlarini, jumladan, albuterol bo'lmagan ingalyatorlarini 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 shifokori bilan maslahatlashganimni tasdiqlayman va agar farzandimda astma 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/shifokorini **darhol** xabardor qilishim kerak
   - 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 qabulining amal qilish muddati tugagach, men farzandimning maktab hamshirasiga/SBHC provayderiga farzandimning birlamchi tibbiy yordam shifokori tomonidan yozilgan yangi dorilarga ruxsat berish shaklini taqdim etaman. Agar bu bajarilmasa, men maktab hamshirasi/SBHC ga farzandimni OSH provayderi tekshirishini istamasligim haqida xat bermagunimcha, farzandimni OSH provayderi tekshirishi mumkin. OSH provayderi mening farzandimning astma belgilari va buyurilgan astma dorilariga javobini baholashi mumkin. OSH provayderi dori qabuli o'zgarmasligi yoki o'zgartirilishi kerakligi haqida qaror qabul qilishi mumkin. Mening farzandim OSH orqali sog'liqni saqlash xizmatlarini olishda davom etishi uchun OSH provayderi yangi MAFni to'ldirishi mumkin. Mening shifokorim yoki OSH provayderim kelajakdagi astma MAFlarini to'ldirish uchun mening imzoyimga muhtoj emas. Agar OSH sog'liqni saqlash mutaxassisi farzandim uchun yangi MAF chiqarsa, u men va farzandimning sog'liqni saqlash mutaxassisiga xabar berishga harakat qiladi.
   - Ushbu shakl mening roziligim va ushbu shaklda tasvirlangan qandli astmani 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 astma ingalyatori, epinefrin 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 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/SBHC 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

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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: ____________

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 ☐ OSH Asthma Case Manager (for supervised students only)

Signature and Title (RN or MD/DO/NP): ____________

Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Clarified ☐ Modified