



# SHIFOKOR TOMONIDAN TAYINLANGAN (NOMEDIKAMENTOZ) SHAKL

Sog'liqni saqlash provayderi tomonidan muolajaga 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 initials: \_\_\_\_\_ Tug'ilgan sanasi: \_\_\_\_\_  
Jinsi:  Erkak  Ayol OSIS #: \_\_\_\_\_ Sini: \_\_\_\_\_ Sini: \_\_\_\_\_ DOE Okrug: \_\_\_\_\_  
Maktab (ATS DBN / nomini, manzilini va tumanini ko'rsating): \_\_\_\_\_

## HEALTH CARE PRACTITIONERS COMPLETE BELOW

ONE ORDER PER FORM (make copies of this form for additional orders).

Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Blood Pressure Monitoring  | <input type="checkbox"/> Feeding Tube replacement if dislodged - specify in #4              | <input type="checkbox"/> Trach Care: Trach. Size _____        |
| <input type="checkbox"/> Chest Clapping/Percussion  | <input type="checkbox"/> Oral / Pharyngeal Suctioning: Cath Size _____ Fr.                  | <input type="checkbox"/> Trach Replacement - specify in #4    |
| <input type="checkbox"/> Clean Intermittent Catheterization:<br>Cath Size _____ Fr.   | <input type="checkbox"/> Ostomy Care  | <input type="checkbox"/> Trach suctioning: Cath Size _____ Fr |
| <input type="checkbox"/> Central Line/PICC Line   | <input type="checkbox"/> Oxygen Administration - specify in #1,<br>including pulse oximetry | <input type="checkbox"/> Other: _____                         |
| <input type="checkbox"/> Dressing Change  | <input type="checkbox"/> Postural Drainage  |   |
| <input type="checkbox"/> Feeding: Cath Size _____ Fr.   | <input type="checkbox"/> Pulse Oximetry – specify in #1                                     |   |
| <input type="checkbox"/> Nasogastric <input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube <input type="checkbox"/> Bolus |   |   |
| <input type="checkbox"/> Pump <input type="checkbox"/> Gravity <input type="checkbox"/> Spec./Non-Standard*                         |   |   |

Student will also require treatment:  during transport  on school-sponsored trips  during afterschool programs

Student Skill Level (select the most appropriate option):

- Nurse-Dependent Student: nurse must administer treatment  
 Supervised Student: student self-treats, under adult supervision  
 Independent Student: student is self-carry/self-treat  
 I attest student demonstrated ability to self-administer the prescribed treatment effectively during school, field trips, and school sponsored events.  
Practitioner's Initials: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS)  
Diagnosis is self-limited:  Yes  No  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

### 1. Treatment required in school:

- Feeding: \*Per the New York State Education Department, nurses are not permitted to administer premixed medications and feedings.  
Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider/specialist.  
Formula Name: \_\_\_\_\_ Concentration: \_\_\_\_\_  
Route: \_\_\_\_\_ Amount: \_\_\_\_\_ Rate: \_\_\_\_\_ Duration: \_\_\_\_\_ Frequency/specific time(s) of administration: \_\_\_\_\_
- Flush with \_\_\_\_\_ mL  Before feeding  After feeding
- Oxygen Administration: Amount (L): \_\_\_\_\_ Route: \_\_\_\_\_ Frequency/specific time(s) of administration: \_\_\_\_\_  
 pm  O2 Sat < \_\_\_\_\_ % Specify signs & symptoms: \_\_\_\_\_
- Other Treatment: Treatment Name: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency/specific time(s) of administration: \_\_\_\_\_  
Specify signs & symptoms: \_\_\_\_\_
- Additional Instructions or Treatment: \_\_\_\_\_

2. Conditions under which treatment should not be provided:

3. Possible side effects/adverse reactions to treatment:

4. Emergency Treatment: Provide specific instructions for clinical personnel (if present) in case of emergency or adverse reactions, including dislodgement or blockage of tracheostomy or feeding tube:

5. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:

6. Date(s) when treatment should be: Initiated: \_\_\_\_\_ Terminated: \_\_\_\_\_

### 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: \_\_\_\_\_

## SHIFOKOR TOMONIDAN TAYINLANGAN (NOMEDIKAMENTOZ) SHAKL

2026-2027 o'quv yili uchun sog'liqni saqlash provayderlaridan dorilarga ko'rsatma shakli

Itimos, maktab hamshirasi/maktab sog'liqni saqlash markaziga murojaat qiling. 1 iyundan keyin topshirilgan arizalarni ko'rib chiqish yangi o'quv yiliga davom etishi mumkin.

### OTA-ONA/VASIY: O'QIDIM, TO'LDIRDIM VA IMZO CHEKDIM. IMZO CHEKISH ORQALI MEN QUYIDAGILARGA ROZILIK BILDIRAMAN:

1. Farzandim shifokorining ko'rsatmalariga muvofiq tibbiy buyumlar, jihozlar va farzandim uchun belgilangan davolash vositalarini maktabda saqlash va tarqatishga rozilik bildiraman.
2. **Men shuni tushunamanki:**
  - Men maktab hamshirasini/maktabdagi sog'liqni saqlash markazi (SBHC) provayderini farzandim uchun tibbiy buyumlar, jihozlar va protseduralar bilan ta'minlashim kerak.
  - **Maktabda beriladigan barcha jihozlar yangi, ochilmagan va asl qadog'ida bo'lishi kerak. Farzandimni maktab kunlarida foydalanishi uchun maktabni joriy, muddati o'tmagan jihozlar bilan ta'minlayman**
    - Materiallar, jihozlar va protseduralarda farzandimning ismi va tug'ilgan sanasi bo'lishi kerak.
  - Farzandimning davolanishi yoki amaliyot shifokori ko'rsatmalaridagi har qanday o'zgarishlar haqida maktab hamshirasini/sog'liqni saqlash provayderini **darhol** xabardor qilishim kerak
  - 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 shaklini imzolash orqali men SBHCga 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 shakldagi davolanish bo'yicha ko'rsatmalar farzandimning o'quv yilining oxirida yoki men maktab hamshirasiga yangi shaklni taqdim etganimda (qaysi biri birinchi bo'lsa) tugaydi, u yozgi sessiyani o'z ichiga olishi mumkin. 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 tibbiy xizmatlarni 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 farmatsevtidan olishi mumkin

**Nyu-York Shtati Ta'lim Departamenti talablariga muvofiq, hamshiralari oldindan aralashtirilgan dorilar yoki qo'shimchalarni qo'llashlari mumkin emas. Hamshiralari bolaning tibbiy yordam ko'rsatuvchi provayderi ko'rsatmasi bo'yicha G-tyubik orqali yuborish uchun dorilar va qo'shimchalarni tayyorlashi va aralashtirishi mumkin.**

### O'Z-O'ZINI DAVOLASH UCHUN (FAQAT MUSTAQIL O'QUVCHILAR UCHUN):

- Men farzandim to'liq tayyorgarlikdan o'tganligini va protseduralarni mustaqil ravishda boshqarishi mumkinligini tasdiqlayman. Men farzandimning maktabda va sayohat paytida ushbu shaklda ko'rsatilgan jihozlarni olib yurishiga, saqlashiga va mustaqil foydalanishiga rozilik beraman. Men yuqorida aytib o'tilganidek, ushbu yorliqqa ega dori-darmonlar va uskunalarni farzandimga berish uchun javobgarman. Shuningdek, men farzandimning muolajalarini nazorat qilish va farzandimning maktabda ushbu muolajalarning barcha natijalari uchun javobgarman. Maktab hamshirasi/SBHC tibbiy yordam ko'rsatuvchi provayderi farzandimning o'zini-o'zi muolaja qilishini tasdiqlaydi. Shuningdek, farzandim o'z-o'zini muolaja qila olmaydigan holat yuz berganda foydalanish uchun, maktabga aniq belgilangan "zaxira" jihozlari yoki buyumlarini taqdim etishga rozilik beraman.

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: \_\_\_\_\_  
Telefon raqami: Kun vaqti: \_\_\_\_\_ Uy: \_\_\_\_\_ Uyali telefoni: \_\_\_\_\_  
Muqobil shoshilinch kontakt:  
Ism: \_\_\_\_\_ O'quvchiga qarindoshlik darajasi: \_\_\_\_\_ 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  
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