



TALVASAGA 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 initials: _____ Tug'ilgan sanasi: _____
Jinsi: Erkak Ayol OSIS #: _____ Sinfi: _____ Sinfi: _____ Ta'lim boshqarmasi okrugi: _____
Maktab (nomini, telefon raqamini, manzilini va tumanini ko'rsating): _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis/Seizure Type: (check all that apply)

- Localization related (focal) epilepsy
- Primary generalized
- Secondary generalized
- Childhood/juvenile absence
- Myoclonic
- Infantile spasms
- Non-convulsive seizures
- Other (please describe below)

Seizure Type	Duration	Frequency	Presentation/Description	Triggers/Warning Signs/Pre-Ictal Phase

Post-ictal presentation: _____

Seizure History: Describe history & most recent episode (date, trigger, pattern, duration, treatment, hospitalization, ED visits, etc.): _____

H/O Status Epilepticus? No Yes Has student had surgery for epilepsy? No Yes - Date: _____ Well Controlled? No Yes

TREATMENT PROTOCOL DURING SCHOOL:

A. Emergency Medication(s) (list in order of administration) [Nurse must administer] ; CALL 911 immediately after administration

Name of Medication	Concentration/Preparation	Dose	Route	Administer After	Side Effects/Specific Instructions
<input type="checkbox"/> diazepam				<input type="checkbox"/> 3 min <input type="checkbox"/> 5 min <input type="checkbox"/> _____ min	
<input type="checkbox"/> midazolam				<input type="checkbox"/> 3 min <input type="checkbox"/> 5 min <input type="checkbox"/> _____ min	

B. In-School/Routine Medications

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: _____

Name of Medication	Concentration/Formulation	Dose	Route	Frequency or Time	Side Effects/Specific Instructions

C. Does student have a Vagal Nerve Stimulator (VNS)? (any trained adult can administer) No Yes, If YES, describe magnet use:

Swipe magnet immediately within _____ min; if seizure continues, repeat after _____ min _____ times; Give emergency medication after _____ min and call 911.

Activities:

Adaptive/protective equipment (e.g., helmet) used? No Yes
Gym/physical activity participation restrictions? No Yes - If YES, please complete the Medical Request for Accommodations Form

Other:

504 Accommodations requested (e.g., supervision for swimming)? Yes (attach form) No

Home Medication(s) <input type="checkbox"/> None	Dosage, Route, Directions	Side Effects / Specific Instructions

Other special instructions: _____

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

TALVASAGA QARSHI DORILARNI QABUL QILISH SHAKLI

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 QUIYIDAGILARGA ROZILIK BILDIRAMAN:

- 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
- Men shuni tushunamanki:**
 - Men farzandimning dorilari va jihozlarini maktab hamshirasi/maktabdagi sog'liqni saqlash markazi (SBHC) provayderiga taqdim etishim kerak.
 - Maktabda beriladigan barcha retsept va retseptsiz dorilar yangi, ochildirilmagan va asl qadog'ida bo'lishi kerak.** Farzandim maktabda bo'lmaganida yoki maktabda bo'lganida ichishi uchun boshqa dori sotib olaman.
 - 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 dorilari yoki sog'liqni saqlash provayderi ko'rsatmalaridagi har qanday o'zgarishlar haqida maktab hamshirasini/sog'liqni saqlash provayderini **darhol** xabardor qilishim kerak
 - Hech bir o'quvchiga noqonuniy moddalarni olib yurish yoki qabul qilishga ruxsat berilmaydi.**
 - 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 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.
 - 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 dori 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, farzandimga 504-bo'lim imtiyozlari rejasini talab etilishi mumkin. Ushbu reja maktab tomonidan tuziladi.
 - 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
 - Men shoshilinch antikonvulsantlar, shu jumladan intranazal dorilar Nyu-York shtati qoidalariga muvofiq faqat hamshira yoki boshqa litsenziyalangan tibbiyot mutaxassisi tomonidan qo'llanilishi mumkinligini tushunaman.

ESLATMA: Farzandingiz uchun dorilar va jihozlarni maktab sayohati kuni va darsdan tashqari mashg'ulotlar uchun yuborish tavsiya etiladi

SHOSHILINCH BO'LMAGAN 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 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.

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

Maktab nomi/Raqami: _____ 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 Office of School Health after consultation with prescribing practitioner: Clarified Modified