Kindergarten Orientation Guide

for Families of Students with Disabilities Entering Kindergarten in Fall 2026

NYC Public Schools

Dear Families,

Moving from preschool to kindergarten marks the start of an exciting new time in your child's life. We know that you may have questions about this move, and we hope that many of them will be answered in this guide. The Kindergarten Orientation Guide provides information for families of children with disabilities who will be entering kindergarten in the fall.

We also invite you to attend our Kindergarten Orientation Meetings, where we will:

- share information about applying to kindergarten (the kindergarten admissions process)
- explain the Kindergarten IEP Process
- describe the special education services provided to school-age students
- answer any other questions that you might have

If you are interested in attending a Kindergarten Orientation Meeting, please call 718-935-2013 for more information, or refer to the schedule on our website: **https://www.schools.nyc.gov/calendar**.

For information about special education in New York City public schools, please read our *Family Guide to Special Education School-Age Services* available **online** at: **schools.nyc.gov/special-education/preschool-to-age-21/special-education-in-nyc**.

We are committed to working together with families to enable our students' success. Our staff will be available to answer your questions and provide help as we plan together for the school year ahead. We look forward to working with you to make your child's move to kindergarten a smooth and successful one!

Sincerely,

Christina Foti
Deputy Chancellor
Division of Inclusive and Accessible Learning
NYC Public Schools

Contents

Special Education in New York City Public Schools

We want to make sure that all students with disabilities:

- have access to challenging classes and are held to appropriately high academic standards
- are taught in classes with students without disabilities as much as possible
- are able to attend either their zoned schools or their schools of interest to the greatest extent possible, while receiving the support they need to succeed

All students with disabilities who require special education services have Individualized Education Programs (IEPs). The IEP is created by a team that includes you, the parent. It contains information about your child's interests, strengths, and needs. The IEP will also identify goals for the school year, and it will describe the special education programs and related services that will be provided to help your child meet these goals.

Special education is not a "class" or a "place." Special education describes a wide range of supports and services:

- An IEP may include different types of classes and services for different parts of the school day.
  - For example, a student who needs extra support in reading might receive reading instruction in a small-class setting and spend the rest of the day in a general education class.
- An IEP may include services to be provided in the classroom.
  - For example, a speech therapist might work with a student during a classroom lesson.
- An IEP may include services to be provided in a different location.
  - For example, a guidance counselor might work with a student in their office.

With plans designed to meet each child's specific needs, schools can provide students with disabilities as much access as possible to general education school courses.

Preparing for Kindergarten: *Two* Processes

Families of all New York City children who turn five years old this year should apply to kindergarten to receive a school offer. The "kindergarten admissions" process is your chance to express your preferences for which school(s) you would like your child to attend (keeping in mind that most children attend the schools in their zone).

As the family of a new kindergartner who may need special education services, you will also participate in the Kindergarten IEP Process or "KIP" process. Through this process, your child's IEP team will determine if they need special education services in kindergarten, and if so, what those services will be. Many kindergartners who need special education services receive them in the school that was offered through the kindergarten admissions process.

Kindergarten Admissions (Applying to Kindergarten)	**Kindergarten IEP Process (Determining Special Education Services and Supports)**
Step 1: From mid-fall through early winter, you should *explore your options* for kindergarten. (**See Page 6**)	**Step 1:** The Kindergarten IEP Process begins when you are contacted by the IEP team. Throughout the process, you will receive several different documents called Prior Written Notices (PWNs). To start, your IEP team will share a PWN titled, "Notice of Recommendation." (**See Page 9**)
Step 2: In winter, you can *apply* to kindergarten. Be sure to submit an application by the deadline. (**See Page 7**)	**Step 2:** If necessary, your child may be reevaluated. (**See Page 9**)
Step 3: If you have applied to kindergarten and submitted your application before the deadline, you will receive an *Offer Letter* in spring. (**See Page 7**)	**Step 3:** If your child has medical needs, you should submit medical forms to your IEP team before your IEP meeting. (**See Page 10**)
Step 4: Once you have received an Offer Letter, you then *register* your child at the school (early through late spring). (**See Page 7**)	**Step 4:** You will come to a kindergarten IEP meeting. Meetings will take place from March through the end of August. The timing of your meeting will depend on when you start the Kindergarten IEP Process. (**See Page 11**)
	Step 5: If your child needs special education services in kindergarten, you will receive a green *School Location Letter.* You will receive this letter toward the end of the school year through the end of August, depending on when you began the Kindergarten IEP Process. (**See Page 13**)

If you apply to kindergarten, the placement you receive on the green *School Location Letter* will be the same school that was listed in your *Offer Letter* (unless your child is recommended for a NYC Public Schools Specialized (District 75) placement on his/her IEP or your child was accepted into a specialized program. If you do not apply to kindergarten, you will not receive an *Offer Letter*, but your child will still receive a school placement following your child's IEP meeting.

Applying to Kindergarten

Children are eligible to attend kindergarten the calendar year they turn five years old. Families should start thinking about school options in the fall and participate in kindergarten admissions in the winter to receive a school offer. "Kindergarten admissions" is separate from the Kindergarten IEP Process. **Students with disabilities should participate in both the kindergarten admissions process and the Kindergarten IEP Process.**

All families with children who are turning five are encouraged to submit a kindergarten application, including those with IEPs. There is no harm in submitting an application. Families who submit a general kindergarten application receive an offer to a school, based only on the admissions priorities of the school. The application does not take the services on the IEP into account. This means that you have the same priority to schools on your application as a student without an IEP.

If at the end of the IEP process you are recommended for a specialized program, you can disregard the offer you received through the general kindergarten application. Instead, you will receive a final placement through the Kindergarten IEP Process. However, if you do not apply and are ultimately recommended for a community school setting, you may miss out on a chance to attend a preferred school. First, the kindergarten admissions process is explained below. Then, details will be shared about the Kindergarten IEP Process.

Kindergarten Admissions

Kindergarten offers are based on the admissions rules at any school. Most schools have an area around them called their "zone." If you live within this area, that school is your "zoned school." To find your zoned school and district, call 311 or visit our website: **schools.nyc.gov/find-a-school**. Children are most likely to attend their zoned school for kindergarten—this is also true for students with disabilities.

All families that submit an application by the deadline will receive an Offer Letter.

Explore Your Options

Visit our kindergarten admissions website at **schools.nyc.gov/kindergarten** to learn about the application process and how offers are made. Visit **myschools.nyc** to explore schools.

Apply

You can apply to your zoned school and any other schools of interest in winter. You do not need to wait for your child's IEP to be completed before you apply, because kindergarten admissions decisions do not take IEPs into account.

There are two ways to submit the Kindergarten application:

- online, at **myschools.nyc**
- over the phone, by calling 718-935-2009

If you need more support, you can contact a Family Welcome Center, Monday through Thursday from 8am to 5pm and Friday from 8am to 3pm (call 311 or visit **schools.nyc.gov/welcomecenters** for information).

The application is available online and in person, in 12 languages. Telephone interpretation is available in more than 200 languages. For more information about applying to kindergarten, visit **schools.nyc.gov/kindergarten** or call 718-935-2009. Sign up to receive email updates about kindergarten admissions at **schools.nyc.gov/Sign-Up**.

Receive an Offer and Register

All families who submit an application by the deadline will receive an offer and information about registering at that school in the spring. Students are automatically added to the waitlist for any school they rank higher than the school they are offered through the process.

Once you receive your offer, you can use **myschools.nyc** to accept your offer online. You can also contact the school directly or call 718-935-2009 to accept your offer over the phone. Once you accept your offer, you will need to contact that school to make an appointment to register.

Note: Even if you register your child at the school where you receive an offer, you can still receive and accept an offer from another school's waitlist. You will need to bring the documents listed in your Offer Letter to the school during the registration period. You do not have to wait for your child's IEP to be completed before you register. In fact, most students with IEPs attend the same school they receive through the admissions process, so we recommend that you register at the school you are offered in the kindergarten admissions process.

If you do not accept your offer and register, you may lose your place at that school.

Note about Accessible Schools

Some school buildings are accessible to students with accessibility needs. For a list of accessible schools, review the kindergarten directory, call 311, or visit our website: **https://www.schools.nyc.gov/school-life/space-and-facilities/building-accessibility.**

Each school or program in our MySchools directory will be labeled one of three accessibility levels: fully accessible, partially accessible, or not accessible:

- A **fully accessible** building is a building that was built after 1992, complies with all of the ADA's design requirements, and has no limits to access for persons with mobility impairments.
- A **partially accessible** building allows persons with mobility impairments to enter and exit the building, get into their programs, and the use of at least one restroom, but other parts of the building may not be accessible.

If your child will need an accessible school, be sure to apply to schools that can meet your child's accessibility needs. It is a good idea to visit in person any school you are interested in listing on the kindergarten application. If your child is determined to have an accessibility need, New York City Public Schools will ensure that your child receives an accessible school placement for kindergarten.

Admissions Resources and Contacts

Visit our website here: **schools.nyc.gov/kindergarten**.

If you have any questions, email **ESenrollment@schools.nyc.gov** or call 718-935-2009.

Applying to Charter Schools

Charter schools are free independent public schools open to all children in New York City. Charter schools have different admission and application processes than New York City Public schools. The deadline to apply for most charter schools is early spring.

Students with disabilities may apply to charter schools. Charter schools are not allowed to deny an application because of a student's disability. Because acceptance to a charter school is not guaranteed, and because charter schools offer admission on a different timeline from New York City Public Schools, you should also submit a New York City Public Schools kindergarten application. If a charter school offers services that meet your child's needs, but do not match your child's IEP, the school may ask the local Committee on Special Education (CSE) to hold a new IEP meeting, and you will be invited.

For more information about charter schools, visit **schools.nyc.gov/enrollment/enroll-in-charter-schools/learn-about-charter-schools**.

Kindergarten IEP Process

NYC Public Schools will work with you to consider your child's need for special education in kindergarten. This is called the "KIP" Kindergarten IEP Process, and it is important for you to be involved. During the Kindergarten IEP Process, NYC Public Schools will assign your child's case to a team at a public school or to a district Committee on Special Education (CSE) office. The team will review your child's file and determine if new assessments are necessary. After any assessments are completed, you will be invited to participate in a kindergarten IEP meeting, as you are considered a member of your child's IEP team.

At the IEP meeting, the IEP team will determine whether your child is eligible to receive special education services in kindergarten. If so, the IEP team will develop an IEP for your child. The IEP will describe the special education programs and related services your child will receive in kindergarten.

Starting the IEP Process

You will be contacted by your child's NYC Public Schools kindergarten IEP team to start the IEP process. The *kindergarten* IEP team is similar to, but not the same as, the IEP team that helps create your child's *preschool* IEP. If your child is receiving preschool special education services by the start of their last year in preschool, you will receive a Welcome Packet in the fall and will be contacted by the NYC Public Schools IEP team in the winter (January-March). If your child starts the preschool special education evaluation process during their last year of preschool and does not have a preschool IEP by March of their last preschool year, you will be contacted after that process is complete, usually in the spring or summer (April-August) before kindergarten.

When you hear from your Kindergarten IEP team, they will introduce themselves and explain the IEP process to you. New York City Public Schools are required to provide documents in writing to families during the IEP process. Throughout the process, you will receive several different documents called Prior Written Notices (PWNs). To start, your IEP team will share a PWN titled, "Notice of Recommendation." This PWN explains that NYC Public Schools is proposing to conduct a reevaluation. A reevaluation will determine if your child continues to be eligible for special education services and, if so, determine what services would meet their needs next year in kindergarten. This PWN will also include contact information for your NYC Public Schools kindergarten IEP team; it will share a staff member's name and phone number. Finally, the PWN may come with a request for your consent to conduct assessments of your child.

Your child's NYC Public Schools IEP team may work at either a New York City public school or at one of the Committee on Special Education (CSE) offices in your borough. The location of your child's IEP team does not necessarily mean your child will go to school where they are located next year. It's simply the team that will work with you on the kindergarten special education process. You and your child's preschool special education teacher and related services providers are also part of the IEP team.

If your child has a preschool IEP and you haven't heard from a New York City Public Schools kindergarten IEP team by March, you can email **KindergartenIEPProcess@schools.nyc.gov**.

If your child was found eligible for preschool special education services but you didn't consent to services or you ended up revoking (taking back) your consent, you will also be contacted in the winter (January-March) to start the kindergarten IEP process. While everything else above is the same, you will receive a slightly different PWN titled, "Notice of Referral." This letter explains that New York City Public Schools proposes to conduct (with your consent) an initial evaluation of your child to determine eligibility for special education services once they enter kindergarten.

New Assessments (if necessary)

New York City Public Schools will review your child's file, including assessments and progress reports from your child's preschool teachers and related service providers. This will help determine what new assessments, if any, will be needed. You will receive communication in the mail or via email informing you if new assessments are needed. If new assessments are needed, you will also receive a letter or email requesting your consent. If you consent, New York City Public Schools may conduct new assessments of your child, which may include observing your child in their preschool classroom.

You also have the right to ask that New York City Public Schools conduct other specific assessments, by writing a letter or emailing your IEP team and New York City Public Schools will review this request. You may give any assessment reports received from outside New York City Public Schools or other documents to your IEP team, if you would like the IEP team to add them to the evaluation. If you have other additional assessment reports or documents, please provide them to your IEP team before the IEP meeting to ensure your child's team has enough time to review and consider these materials.

If new assessments are conducted, you will receive copies of the reports before the IEP meeting.

Provide Medical Forms before the IEP Meeting (if applicable)

If your child requires medication or treatment during the school day or specialized transportation accommodations, due to a medical/mobility need, you will need to provide your IEP team with a Medical Accommodation Request Form (MARF), medication administration forms and/or treatment order forms completed by your child's doctor. Your IEP team can provide you with this packet or you can obtain them **online** from the New York City Public Schools website: **schools.nyc.gov/school-life/health-and-wellness/health-services**.

Please submit the forms to your IEP team as soon as they are completed by your doctor. Incomplete forms will delay processing and may delay the start of services. Please keep copies for your own records. If your child receives medical treatments or nursing services during the school day, you will also need to submit updated medical forms during the summer before the new school year.

Note on Curb-to-School (Specialized) Transportation

New York City Public Schools provides curb-to-school (specialized) transportation to students whose Individualized Education Programs (IEPs) recommend this service because the student cannot walk to school or safely take public transportation with their parent/guardian.

Curb-to-school transportation is when a bus picks up a student from the safest curb nearest their home and drops them off at their school. For students with IEPs, only students who have curb-to-school busing recommended on their **Individualized Education Program**, are eligible for curb-to-school transportation. Curb-to-school buses are staffed by both a school bus driver and an attendant.

For some students receiving curb-to-school busing, New York City Public Schools will also provide accommodations required by the student's medical needs or mobility limitations. These may include 1:1 nursing or health paraprofessional services, adaptive car seat, and/or limited travel time. If your child needs any such services or accommodations, you will need to provide a HIPAA authorization and the Medical Accommodation Request Form (MARF), completed by your child's physician, to your IEP team as far in advance of the IEP meeting as possible.

If your child is not recommended for curb-to-school busing, they may be assigned to a school bus stop on a stop-to-school route, depending on where you live in relation to the school you select and whether the school offers stop-to-school bus service. Reach out to the school's transportation coordinator to learn more about the school's transportation options.

Kindergarten IEP Meeting

You will receive a letter with the date, time, and location of your child's **Individualized Education Program** (IEP) meeting at least five days before the meeting.

Your child's IEP meeting will likely take place at your child's zoned elementary school, starting in late winter (since many KIP cases are assigned to their zoned school). Please know that having an IEP meeting at a particular school does not mean that your child will attend school there.

You, the parent or guardian, are a very important member of the IEP team. Other IEP team members may participate in person, virtually, or over the phone, and may include:

- **Your child's current teachers and related service provider(s) are highly encouraged to participate**
- A representative from the school for which your child received an offer for kindergarten
- A school psychologist
- Others with knowledge about your child or special expertise

If you only speak a language other than English, let your IEP team know ahead of your meeting that you will need an interpreter, and New York City Public Schools will provide one.

A "parent member" is a parent of another child who has had an IEP. You may ask for a parent member to join your child's IEP meeting. You may also ask for a school physician to join the meeting. If you want a parent member or physician to attend the IEP meeting, you must request this in writing to your IEP team at least 72 hours before the meeting.

Eligibility for Special Education Services in Kindergarten

At the kindergarten **IEP** meeting, the IEP team will:

- Determine whether your child needs special education in kindergarten ("eligibility"), and if so,
- Develop an IEP or Individualized Education Services Plan (IESP) for kindergarten.

If your child is not eligible, the IEP team will prepare paperwork to indicate that your child is not eligible or has been "declassified."

In preschool, every student with an IEP is identified ("classified") as a "Preschool Student with a Disability" on the IEP. For kindergarten and the grades above, your child must meet the criteria for one of the 13 disability classifications described in **Appendix A**. The classification will be listed on your child's IEP or IESP.

Declassified/Ineligible

If your child has a preschool IEP but the IEP team finds that your child is not eligible to receive special education services in kindergarten, your child will be "declassified." If your child is declassified, your child will enter a general education class for kindergarten. In this case, the IEP team may recommend support services during your child's first year without special education. These "declassification support services" may include:

- instructional support
- accommodations
- or related services, such as speech therapy or counseling

If your child does not have a preschool IEP and is being evaluated for the first time, and the IEP team finds that your child does not meet the criteria for one of the 13 disability classifications, your child will be found "ineligible" for special education services. In this case, your child will enter a general education class for kindergarten.

If your child does not meet the criteria for one of the 13 educational disability classifications but has certain health or behavioral needs that may require accommodations to participate fully in school programs or activities, your child may be eligible for Section 504 Accommodations. For more information on 504 plans and accommodations, refer to **schools.nyc.gov/school-life/health-and-wellness/504-accommodations** on the NYC Public Schools website or speak to the school 504 coordinator or guidance counselor at the beginning of the kindergarten year.

Kindergarten Individualized Education Program (IEP)

If your child needs special education services in kindergarten, an IEP will be developed. The IEP will include information about your child's strengths, interests, and particular needs. The IEP team will set goals describing what skills your child will work on developing in kindergarten. The IEP team will then decide what support, services, and school setting your child will need in order to reach those goals. After the IEP meeting, a copy of the IEP will either be given to you or mailed to you within two weeks.

Kindergarten Individualized Education Services Plan (IESP)

If your child will attend a private or religious school in New York City, your child may be eligible to receive special education services and related services there, provided by New York City Public Schools. If you have decided to send your child to a private or religious school, you should inform your IEP team that you will not be seeking special education in a public school. If your child is eligible for special education, the IEP team will develop an Individualized Education Services Plan (IESP). The IESP will describe the special education services and related services to be provided while your child attends a private or religious school. You will need to provide your IEP team with the name and address of the private or religious school your child will attend. If you are unsure of what school your child will attend, the IEP team should develop an IEP instead.

If you have decided to enroll your child in a school *outside* of New York City, you should inform your IEP team. They will provide you with information about contacting the school district where the school is located, and that district will work with you to develop a plan and provide any special education services.

If your plans change at any time after an IESP is developed for you and you would like to instead request an IEP and a public-school placement, contact your IEP team to ask for a new IEP meeting.

Receive School Location Letter

You will receive a green "School Location" letter in the mail. You should expect to receive this between late Spring through the end of Summer. This notice includes information about your child's IEP and the school that will provide the recommended special education services—this is called a "placement." You will only receive a green School Location Letter if your child has been recommended for a Non-Specialized District 1-32 or Specialized District 75 school.

Most students receive a placement recommendation to a District 1–32 school (**see Page 15**). The following are three scenarios where your child's placement may be in a District 1–32 school, depending on how you've applied:

- If you apply to kindergarten, your child's services will be provided in the school where your child received an offer and is registered.
- If you do not apply to kindergarten, your child will be assigned a school in the district where you live, and your child's services will be provided there.
- If your child is accepted to a "specialized program" (such as Horizon, Nest, or ACES), your child will receive a placement at a school that can provide that program (**see Page 16**).

If your child's IEP recommends a Specialized (District 75) school, your child will receive a placement at an appropriate District 75 school (**see Page 19**).

If your child's IEP recommends a state-approved, state-supported, or state-operated non-public school, the recommended services will be provided at the school where your child was accepted.

If your child requires an accessible school, your child will receive a placement in such a school.

Family Meeting

After receiving the green School Location letter, the staff at your child's new school may invite you to a "family meeting" if this school did not participate in your child's kindergarten IEP meeting. This meeting will give you a chance to visit the school, look over your child's IEP with school staff, share information about your child, and ask any questions you may have about the services recommended on the IEP. The family meeting will be an informal conversation. If you prefer to connect by phone or do not want to meet at all, please inform the school. If you would like to visit the school or have a family meeting, you can contact the school's parent coordinator or principal.

KIP Resources and Contacts

Contact your IEP team with any questions or concerns. Your IEP team will support you through the Kindergarten IEP Process. Contact information for your IEP team can be found on the Notice of Recommendation (or Notice of Referral) sent at the start of the Kindergarten IEP Process. You can also view "How to Get Help" (**see Page 26**).

You can also visit our website at: **schools.nyc.gov/Kindergartenspecialeducation**.

If you have any other questions about the KIP process, email **KindergartenIEPProcess@schools.nyc.gov** or call 718-935-2007.

Special Education Services in District 1–32 Schools

The majority of students with IEPs attend the same schools that they would attend if they did not have an IEP. The following are educational programs children may receive in a District 1–32 school.

General Education with Related Services

Your child will be educated in the same classroom as non-disabled students and will receive their related services (such as speech-language therapy or counseling) in the classroom or in a separate location. **See page 20** for details of the most common related services.

General Education with Special Education Teacher Support Services (SETSS)

Your child will be educated in the same classroom as non-disabled students and will receive support from a special education teacher. Your child's IEP may recommend direct SETSS or a combination of direct and indirect SETSS.

- **Direct SETSS**: A special education teacher provides specially designed instruction for part of the school day directly to a group of up to eight children. This may take place in the general education classroom or somewhere else in the school.
- **Indirect SETSS:** A special education teacher works together with the general education classroom teacher to adjust the learning environment and modify instruction to meet students' needs.

Integrated Co-Teaching (ICT)

Integrated Co-Teaching (ICT) classes are general education classes serving both students with IEPs and students without IEPs. No more than 12 (or 40 percent) of the students in the class can have IEPs. There are 2 teachers in the classroom at all times—a general education teacher and a special education teacher. The teachers work as a team, and they work together to adjust lessons and modify instruction to make sure the entire class can take part.

Special Class

In a special class, all of the children have IEPs and have needs that cannot be met in a general education classroom. They are taught by a special education teacher who provides specialized instruction. Special classes in District 1-32 elementary schools have up to 12 students whose ages are within a three-year range and who have similar educational needs. The special class may include a paraprofessional for additional support. Special classes are often referred to by their staff-to-student ratio:

- 12:1 (12 students, one special education teacher)
- 12:1+1 (12 students, one special education teacher, one classroom paraprofessional)

Specialized Programs in District 1–32 Schools

Specialized programs are uniquely designed classroom environments and service models. Your child's IEP team may discuss specialized programs at your child's IEP meeting if your child has an autism, intellectual, multiple, or emotional disability educational classification or is recommended for bilingual special education. For certain specialized programs, you may need to submit an application. If it is determined that your child could be supported in a specialized program, they may be placed in a different school than the one you were already offered through the kindergarten admissions process. Specialized programs include:

Academics, Career, and Essential Skills (ACES) Program

ACES programs provide students with an opportunity to learn academic, work, and life skills in a District 1-32 school. ACES programs support some students who are classified as having an intellectual disability (ID) or multiple disabilities (MD) in a smaller class setting.

If you think the ACES program may be right for your child, discuss with your child's school and IEP team, and you may submit an application to the Central ACES Team at any time. The applications are found on our website: **schools.nyc.gov/special-education/school-settings/specialized-programs** or one can be emailed to you if you contact the ACES Team at **ACESprograms@schools.nyc.gov**.

School staff can also help you through the application process. The ACES Team will work with you and the IEP team to make sure all assessments are current (made within one year of the application). For children entering kindergarten in September, families or schools should contact the Central ACES Team as soon as possible.

Autism Programs

The *Nest*, *Horizon*, and *AIMS* programs are three NYC Public School programs supporting autistic learners. They are available in District 1–32 and D75 schools. Each program works to build academic, language, communication, and social skills.

The *Nest* program provides a smaller ICT setting in certain District 1-32 schools for students with autism. Most Nest students are at or above grade level and can work independently for periods of time.

The *Horizon* program is a special class for up to eight students, with one special education teacher and one paraprofessional. Horizon students may be approaching grade-level standards in some subjects, requiring small group instruction or other supports and modifications to be successful.

The *AIMS* program is an early childhood program offered in grades kindergarten to second. It provides a small class setting of 6 autistic learners who have intensive support needs in areas related to learner readiness, language, communication, activities of daily living, and behavior.

Components of the AIMS program:

- Applied Behavior Analysis (ABA) uses an evidence-based approach to understand and improve behaviors to support students' engagement.
- Verbal Behavior which is a method to teach communication and language.
- Teaching methods to adapt the classroom environment for the needs of students, including visuals, schedules, and systems of organization.

If you think an autism program may be right for your child, you may submit an application to the Central Team at any time. School staff can help you through the application process.

Please submit an electronic application through NYC Public Schools website: **schools.nyc.gov/special-education/school-settings/specialized-programs**. If you have difficulties, please work with your child's school or IEP team to submit an application. The Team will work with you and the IEP team to make sure all assessments are current. For children entering kindergarten in September, families or schools should contact the Central Team as soon as possible by emailing **autismprograms@schools.nyc.gov**.

Bilingual Special Education

Bilingual special education is a program for students whose IEPs recommend an ICT or special class setting with a language of instruction other than English. These programs support Multilingual Learners (MLLs) with disabilities who benefit from instruction in their familiar culture and language. Information can be found on the website: **schools.nyc.gov/special-education/school-settings/specialized-programs** or refer to the Bilingual Special Education Family Resource Guide, which can also be found on the same **website**.

Path

The Path Program provides class-wide social-emotional support as well as direct instruction of emotional regulation skills for individual students. Path program is an inclusive classroom setting; using an integrated co-teaching (ICT) model, where teachers, social workers, and occupational therapists support. Teachers and related service providers use trauma-informed instructional practices and provide social-emotional and behavioral supports in the classroom. More information can be found on the website: **Specialized Programs for Students with Disabilities (nyc.gov)** or contact **pathprograms@schools.nyc.gov** to speak with a team member.

More Information

For more information about specialized programs in District 1-32 schools and for information on how to find out if your child is eligible, visit the specialized programs website: **schools.nyc.gov/special-education/school-settings/specialized-programs** or email **specializedprograms@schools.nyc.gov.**

District 75

District 75 provides highly specialized instructional support for students with significant challenges. District 75 programs may be provided in special classes located in school buildings that also have District 1-32 schools or in school buildings where all students have an IEP. Certain District 75 services may be provided in general education classrooms.

District 75 classes serving kindergarten students include:

Special Class Ratio	Description
12:1+1 · 12 students · One teacher · One paraprofessional	For students with academic and/or behavioral management needs that interfere with the instructional process and require additional adult support and specialized instruction.
8:1+1 · 8 students · One teacher · One paraprofessional	For students whose needs are severe and chronic and require constant, intensive supervision, a significant degree of individualized attention, intervention, and behavior management.
6:1+1 · 6 students · One teacher · One paraprofessional	For students with very high needs in most or all areas including academic, social and/or interpersonal development, physical development, and management. Classes provide highly intensive individual programming, continual adult supervision, a specialized behavior management program to engage in all tasks, and a program of speech/language therapy (which may include augmentative/alternative communication).
12:1+4 · 12 students · One teacher · One paraprofessional for every three students	For students with severe and multiple disabilities with a variety of difficulties that include limited language, academic and independent functioning. Classes provide a program that follows an adjusted curriculum with alternative access to instruction, training in daily living skills, development of communication skills, sensory stimulation, and therapeutic interventions.

District 75 also provides special class services for students with significant hearing and vision impairments. Specialized equipment and services are used throughout the school day. Services include audiology, assistive technology, sign language interpretation, orientation and mobility services, and Braille.

Visit our website: **district75nyc.org** or call 212-802-1500 for more information and a list of program sites.

Related Services

Your child's IEP may recommend related services. Related services are intended to help a student achieve their educational goals. Your child's IEP may recommend related services in the classroom, where related service providers can work with teachers, paraprofessionals, and other adults to support students. Or your child's IEP may recommend related services in other locations in the school. Your child's IEP may recommend related services one-on-one or in a small group. Examples of related services:

- **Counseling**: Helps students improve their social and emotional skills in school. Goals may work toward appropriate school behavior and self-control, peer relationships, conflict resolution, and boosting self-esteem.
- **Hearing Education Services**: Helps students who are deaf or have hearing impairments improve their communication skills. Goals may focus on speechreading (also known as lip-reading), auditory training (listening), and language development.
- **Occupational Therapy**: Helps students to function in all education related activities, including life skills (such as eating and self-care) and social skills through the development of:
  - Fine motor skills (arms, hand, and finger movement)
  - Visual motor skills (hand-eye control)
  - Sensory processing (how to use information from the senses)
  - Cognitive functioning (problem solving, memory, attention skills)
- **Orientation and Mobility Services**: Helps students with visual impairments improve their ability to be aware of, and move safely in, their environments.
- **Physical Therapy**: Helps students access the educational environment, including, but not limited to
  - School mobility (access to various areas of the school via walking, wheelchair, or other means of mobility)
  - Classroom activities (function related to participating physically and maneuvering within the classroom environment)
  - Accessing and participating in the lunchroom, playground, bathroom, transportation, etc.
  - Transitioning from school to post-school activities
- **School Nurse Services**: Helps students who have health-related needs stay safe and participate in school.

- **Speech/Language Therapy**: Helps students develop listening and speaking skills. Goals may address:
  - Phonological skills (organizing speech sounds)
  - Comprehension (understanding language)
  - Expressive Language (combining words into meaningful sentences)
  - Articulation (forming clear sounds in speech)
  - Social language skills
- **Vision Education Services:** Helps students who are blind or have visual impairments to use braille. Facilitate inclusive practices to support all students. Related service recommendations should:
  - Be recommended in the student's natural learning environment and in groups that are appropriate for the student.
  - Individual services recommended to develop specifically identified skills.
  - Individual recommendations should be reviewed consistently to determine an appropriate time in which to recommend a more inclusive service mandate (natural learning environment.)
  - IEP recommended related services should be reviewed annually with a focus on inclusive practices.

Other Programs and Services

Some other programs and services that may be recommended on a student's IEP are described below.

Assistive Technology Devices & Services

An assistive technology (AT) device is any piece of equipment, product, or system that is used to increase, maintain, or improve a child's functional abilities, such as communication boards, communication devices, FM units, and computer or tablet access. Assistive technology services provide help in successfully using these devices.

Adapted Physical Education

Adapted physical education (APE) is a specially designed instructional program of developmental activities, games, sports, and rhythms based on the interests, abilities, and limitations of students with disabilities. The IEP team will recommend APE for your child if their disability would prevent safe or successful participation in a school's regular physical education program with or without modifications.

Extended School Year Services (12-Month Services)

Extended school year services are provided for students with disabilities who require special instruction and/or related services during the summer in order to maintain progress gained during the school year.

Home and Hospital Instruction

Home and hospital instruction are educational services provided to students with disabilities whose emotional or medical needs prevent them from attending school. They are provided only until a child is able to return to school or is discharged from the hospital. They might also be provided in the rare instance that a child is waiting for his or her placement that is not yet available.

Paraprofessional Services

Paraprofessionals are aides—not teachers—who work with students who require adult support beyond that provided by teachers and service providers. Paraprofessionals may support an entire class or work with one or more children at a time. They may work with children for all or part of the school day. Paraprofessionals may help with behavior management or with health needs. They may also be recommended to assist with orientation and mobility or toilet training.

Other Placement Recommendations

Students whose needs cannot be met in a District 1-32 or District 75 school may instead receive a placement recommendation for one of the settings listed below.

NY State Education Department (NYSED) Approved Non-Public Schools

New York State Education Department (NYSED)-approved schools are non-public schools that provide programs for children whose intensive educational needs cannot be met in public school programs. NYSED-approved non-public schools are attended only by students with disabilities. NYSED-Approved Non-Public Schools can be provided for the duration of the school day ("day") or 24 hours a day ("residential").

NYSED-approved residential schools serve children whose educational needs are so intensive that they require 24-hour attention. NYSED-approved residential schools provide intensive programming in the classroom, together with a structured living environment, on school grounds 24 hours a day.

If the IEP team recommends a non-public school placement on your child's IEP, the IEP team will seek assistance from the Central Based Support Team (CBST). CBST is the New York City Public Schools office that matches students with state-approved non-public schools. A CBST case manager will apply to non-public schools for your child. You should participate in the application process, which may include interviews or other visits with schools.

NY State Education Department (NYSED) Supported Schools

State-supported schools (also known as "4201 schools") provide intensive special education services to eligible children who are deaf, blind, or have severe emotional or medical disabilities. The IEP team will decide if a child needs this type of program. Some state-supported schools are day schools, and some provide residential care five days a week for children who need 24-hour programming. If you believe a state-supported school may be appropriate for your child, your IEP team can help you with the process.

Parents' Rights During the Transition from Preschool

As the parent of a student entering kindergarten, you have a number of rights.

- You have the right to consent or to withhold your consent to any new assessments that the IEP team determines are required. However, if your child has a preschool IEP and the IEP team makes efforts to obtain your consent and you do not respond, the assessments may be conducted without your consent.
- You have the right to request that specific assessments be conducted by writing to your IEP team.
- You have the right to provide the IEP team with copies of privately conducted assessment reports and to have the IEP team review and consider these reports.
- You have the right to be an equal member of your child's IEP team and to participate meaningfully in decision-making through attendance at all IEP meetings.
- You have the right to invite other individuals with knowledge or special expertise about your child to attend IEP meetings, to help in the decision-making process.
- You have the right to receive copies of your child's assessments and progress reports before IEP meetings and receive copies of your child's IEP within two weeks of your child's IEP meeting.
- You have the right to request another IEP meeting, mediation, or an impartial hearing, or file a complaint with New York State, if you disagree with decisions made about your child.
- You have the right to revoke (withdraw) your consent for all special education programs and related services at any time by writing a letter to the IEP team. If you do, your child's educational record will indicate that your child received preschool special education services.
- You have the right to a language interpreter for IEP meetings. You also can obtain a translation of your child's IEP, assessment reports or notices, or additional interpretation assistance in connection with your child's IEP by contacting your IEP team.
- You have the right to receive notification about special education placement and services within specific timeframes. For a student who will turn five years old this calendar year and who will enter Kindergarten in the fall:

If a referral is received…	…placement must be offered by:
From September 1st through March 1st	**June 15th**
From March 2nd through April 1st	**July 17th**
From April 2nd through May 10th	**August 15th**
From May 11th through August 31st	**60 school days from the date of the referral**

This means that if your child had a preschool IEP before March, or if you refer your child for special education evaluation before March, New York City Public Schools must notify you about services and placement for September by June 15. New York City Public Schools will specify the services that will be provided to your child and will name the school where your child will receive these services.

- Please call 311 or email **KindergartenIEPProcess@schools.nyc.gov** if you have not received a placement offer by mail within a few days of the deadlines listed above. If the IEP recommends a special class and New York City Public Schools does not offer the recommended placement within the timeframes in the chart above, you may have the right to place your child in an appropriate program in a New York State Education Department-approved non-public school, at no expense to you.
- You have the right to request an independent assessment paid for by New York City Public Schools if you do not agree with an evaluation conducted by New York City Public Schools. You must notify New York City Public Schools of this request in writing. New York City Public Schools will either agree to pay for an independent assessment or will file for an impartial hearing to show that its evaluation is sufficient.
- You have the right to an independent assessment paid for by New York City Public Schools if New York City Public Schools did not complete the assessment(s) within the timeline in the table below (unless New York City Public Schools was not responsible for the delay).

If a request for a reevaluation is received…	…the evaluation must be completed by:
From September 2nd through March 3rd	**June 2nd**
From March 4th through April 1st	**July 1st**
From April 2nd through May 12th	**August 1st**
From May 13th through August 29th	**60 school days from the date of the referral**

For more information about the rights of parents of students with disabilities, see our *Family Guide to Special Education School-Age Services* available **online** at **schools.nyc.gov/special-education/help/contacts-and-resources** and the New York State Education Department's *Procedural Safeguards Notice: Rights for Parents of Children with Disabilities, Ages 3–21* (Statement of Family's Rights) available **online** at **schools.nyc.gov/special-education/help/your-rights**. Both documents are also available in schools.

How to Get Help

Your New York City Public Schools IEP Team

Questions? A representative from a school or a CSE office will help you as your child moves to school-age special education services. This should be the first person you contact with questions or concerns. Your IEP team is also listed on the Prior Written Notice (PWN) sent at the start of the Kindergarten IEP Process.

Additional Help

If you have a problem that cannot be resolved by your IEP team or CSE district office, you can ask for more help by calling 311 or emailing **KindergartenIEPProcess@schools.nyc.gov.**

Please provide the following information:

- Your child's name, date of birth, and NYC ID
- Name and number of the school or CSE that sent you information, or held the IEP meeting
- A brief description of your concern

You can also contact the organizations listed below for assistance.

Special Education Parent Centers

The Special Education Parent Centers, funded by the New York State Education Department, provide information and resources to families of children with disabilities.

INCLUDEnyc

116 East 16th Street, 5th Floor
New York, NY 10003
212-677-4660 (English)
212-677-4668 (Spanish)
Web: **includenyc.org**
Serves Bronx, Brooklyn, Manhattan, and Queens
(Also serves as citywide Parent Training and Information Center)

Parent to Parent of NY State

Institute for Basic Research
1050 Forest Hill Road
Staten Island, NY 10314
(718) 494-4872
Web: **parenttoparentnys.org/offices/Staten-Island/**
Serves Staten Island

Parent Training and Information Centers (PTICs)

PTICs are funded by the US Department of Education's Office of Special Education Programs to meet the needs of families of children with disabilities.

Advocates for Children of New York

151 West 30th Street, 5th Floor
New York, NY 10001
Helpline: 866-427-6033
Web: **advocatesforchildren.org**

Sinergia/Metropolitan Parent Center

2082 Lexington Avenue, 4th Floor
New York, NY 10035
212-643-2840
Web: **sinergiany.org**

Appendix A: Disability Classifications

A student in grades K-12 is eligible for special education if they meet the criteria for one or more of the disability classifications described below and, for that reason, they need a special education program or related service.

More information can also be found in the New York State Regulations of the Commissioner of Education: **http://www.p12.nysed.gov/specialed/lawsregs/documents/regulations-part-200-201-oct-2016.pdf**

Disability Classification	Description
Autism	A developmental disability, mainly affecting a child's social and communication skills. It can also impact behavior and covers a wide range of symptoms.
Deafness	A student with a hearing impairment is unable to hear most or all sounds even with a hearing aid.
Deaf-Blindness	A student with both severe hearing and vision loss. Communication and other developmental and educational needs are so unique that programs for students with deafness or with blindness cannot meet their needs.
Emotional Disturbance	A student who exhibits one or more of the following characteristics over a long period of time and to a degree that adversely affects the student's educational performance: · An inability to learn that cannot be explained by intellectual, sensory, or health factors · An inability to build or maintain satisfactory relationships with peers and teachers · Inappropriate types of behavior or feelings under normal circumstances · A generally pervasive mood of unhappiness or depression · A tendency to develop physical symptoms or fears associated with personal or school problems
Hearing Impairment	A student with a hearing loss not covered by the definition of deafness. This type of hearing loss can change over time.
Intellectual Disability	A student with significantly below average intellectual ability and adaptive (life) skills. A student may also have poor communication, self-care and social skills.
Learning Disability	This is an umbrella term that covers learning challenges that impact a student's ability to read, write, listen, speak, reason or do math.
Multiple Disabilities	A student with more than one condition that creates educational needs that cannot be met in a program designed for any one disability.
Orthopedic Impairment	An orthopedic impairment means that a student lacks function or ability in their body; for example, cerebral palsy.
Other Health Impairment	This is an umbrella term that covers conditions that limit a student's strength, energy, or alertness. One example is ADHD which impacts attention.
Speech or Language Impairment	A student with a communication disorder, such as stuttering, impaired articulation, a language impairment or a voice impairment that makes it hard for a student to understand words or express themselves.
Traumatic Brain Injury	A student with an injury to the brain caused by an accident or some kind of physical force.
Visual Impairment	A student whose eyesight impacts their educational performance. Any vision problem that cannot be corrected by eyewear qualifies, including partial sight and blindness.

Appendix B: Websites and Contact Information

Important New York City Public Schools Websites and Contacts

Below is a listing of New York City Public Schools web pages and other contact information that you may find useful.

New York City Public Schools
Website: **schools.nyc.gov**

Kindergarten Admissions Process
Website: **schools.nyc.gov/Kindergarten**
Email: **ESenrollment@schools.nyc.gov**
Phone: 718-935-2009
Subscribe for updates: **schools.nyc.gov/subscribe**
Search for schools: **schools.nyc.gov/find-a-school**

Special Education
Website: **schools.nyc.gov/specialeducation**
Email: **specialeducation@schools.nyc.gov**
Hotline: 718-935-2007

Kindergarten IEP Process
Website: **schools.nyc.gov/special-education/preschool-to-age-21/moving-to-Kindergarten**
Email: **KindergartenIEPProcess@schools.nyc.gov**

District 75
Website: **district75nyc.org**
Email: **D75info@schools.nyc.gov**
Phone number: 212-802-1500

Specialized Programs
Website: **schools.nyc.gov/special-education/school-settings/specialized-programs**
Email: **SpecializedPrograms@schools.nyc.gov**

- ACES: **ACESPrograms@schools.nyc.gov**
- NEST/Horizon: **autismprograms@schools.nyc.gov**
- Bilingual Special Education: **BSEprograms@schools.nyc.gov**

For information on the topics listed below, please visit the associated website:

- Accessible schools: **schools.nyc.gov/Offices/OSP/Accessibility**
  - For a list of accessible schools look under 'Accessible Schools' on the website above
- Charter schools: **schools.nyc.gov/community/charters**
- School Health Forms: **schools.nyc.gov/school-life/health-and-wellness/health-services**
- Transportation: **schools.nyc.gov/school-life/transportation/transportation-overview**

Appendix C: Medication Administration Forms

Please see the next couple of pages for copies of the Medication Administration Forms. You can also request copies of these forms from your IEP team and find them **online** at **schools.nyc.gov/school-life/health-and-wellness/health-services**.

Attach student photo here

GENERAL MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR DIABETES, SEIZURE, ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form I Office of School Health I School Year **2025-2026**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female OSIS Number: _____ Grade: _____ Class: _____ DOE District: _____

School (include name, number, address, and borough): _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

1. Diagnosis:_____ ICD-10 Code: ☐ ____. ____

Medication (Generic and/or Brand Name): _____

Preparation/Concentration: _____ Dose: _____ mg Route:_____

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 - *Initial below for Independent (Not allowed for controlled substances)
  - ☐ Practitioner's Initials: _____ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events

In School Instructions

- ☐ Standing daily dose – at _____ and _____ **and/or**
- ☐ PRN - specify signs, symptoms, or situations: _____
  - ☐ Time Interval: _____ minutes or _____ hours as needed
  - ☐ If no improvement, repeat in _____ minutes or _____ hours for a maximum _____ of times.

Conditions under which medication should not be given:_____

2. Diagnosis:_____ ICD-10 Code: ☐ ____. ____

Medication (Generic and/or Brand Name): _____

Preparation/Concentration: _____ Dose: _____ mg Route:_____

Student Skill Level (select the most appropriate option):

- ☐ Nurse-Dependent Student: nurse/nurse-trained staff must administer
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry/ self-administer - * Initial below for Independent (Not allowed for controlled substances)
  - ☐ Practitioner's Initials: _____ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events

In School Instructions

- ☐ Standing daily dose – at _____ and _____ **and/or**
- ☐ PRN - specify signs, symptoms, or situations: _____
  - ☐ Time Interval: _____ minutes or _____ hours as needed
  - ☐ If no improvement, repeat in _____ minutes or _____ hours for a maximum _____ of times.

Conditions under which medication should not be given:_____

3. Diagnosis:_____ ICD-10 Code: ☐ ____. ____

Medication (Generic and/or Brand Name): _____

Preparation/Concentration: _____ Dose: _____ mg Route: _____

Student Skill Level (select the most appropriate option):

- ☐ Nurse-Dependent Student: nurse/nurse-trained staff must administer
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry/ self-administer - * Initial below for Independent (Not allowed for controlled substances)
  - ☐ Practitioner's Initials: _____ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events

In School Instructions

- ☐ Standing daily dose – at _____ and _____ **and/or**
- ☐ PRN - specify signs, symptoms, or situations: _____
  - ☐ Time Interval: _____ minutes or _____ hours as needed
  - ☐ If no improvement, repeat in _____ minutes or _____ hours for a maximum _____ of times.

Conditions under which medication should not be given:_____

Home Medications (include over the counter) ☐ None

_____

Health Care Practitioner

Last Name:_____ First Name: _____ Please select one: ☐ MD ☐ DO ☐ NP ☐ PA

Signature: _____ Date: _____ NYS License # (Required): _____ NPI #: _____

Address: _____ E-mail address: _____

Tel No: _____ FAX: _____ Cell Phone: _____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 →

GENERAL MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR DIABETES, SEIZURE, ASTHMA OR ALLERGY MEDICATIONS Provider Medication Order Form | Office of School Health | School Year **2025-2026**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

PARENTS/GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. **I understand that:**
   - I must give the school nurse/school based health center (SBHC) my child's medicine and equipment.
   - **All prescription and "over-the-counter" medicine** I **give the school must be new, unopened, and in the original bottle or box.** I will provide the school with current, unexpired medicine for my child's use during school days.
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I must **immediately** tell the school nurse/SBHC provider about any change in my child's medicine or the health care practitioner's instructions.
   - **No student is allowed to carry or give him or herself controlled substances.**
   - The Office of School Health (OSH) and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), OSH may provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse/SBHC provider a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse/SBHC provider a new MAF written by my child's health care practitioner.
   - This form represents my consent and request for the medication services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Section 504 Accommodation Plan.This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication, or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

FOR SELF-ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself, the medicine prescribed on this form in school and on trips. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse/SBHC provider will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

Student Last Name: _____ First Name: _____ MI: _____ Date of birth: _____

School (ATS DBN/Name): _____ Borough: _____ District: _____

Parent/Guardian Name (Print): _____ Parent/Guardian's Email: _____

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Address: _____

Telephone Numbers: Daytime: _____ Home_____ Cell Phone: _____

Alternate Emergency Contact:

Name: _____ Relationship to Student: _____ Phone Number:_____

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 as per OSH contact with prescribing health care practitioner: ☐ Clarified ☐ Modified

UPDATED

Attach student photo here

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2025-2026

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle Initial:_____ Date of Birth: _____

Sex: ☐ Male ☐ Female OSIS Number: _____ Grade: _____ Class: _____ DOE District: _____

School (include: ATS DBN/Name, address, and borough):_____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
- ☐ Asthma
- ☐ Other: _____

Control (*see NAEPP Guidelines*)
- ☐ Well Controlled
- ☐ Not Controlled / Poorly Controlled
- ☐ Unknown

Severity (*see NAEPP Guidelines*)
- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent
- ☐ Unknown

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

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

Home Medications (include over the counter) ☐ **None**

☐ Reliever: _____ ☐ Controller: _____ ☐ Other: _____

Student Skill Level (select the most appropriate option):
- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ 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

Individual spacers are provided by the school. Schools will only provide Albuterol MDI and Fluticasone 110 ucg

Emergency Plan: If in Respiratory Distress: call 911 and give albuterol 6 puffs: may repeat Q 20 minutes until EMS arrives!

Standard Albuterol Order: *Albuterol: Give 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**: Name:_____ Dose: _____ puffs/ _____ AMP 15-20 mins before exercise.

☐ **URI Symptoms/Recent Asthma Flare:**

Name:_____ Dose: _____ puffs/ _____ AMP q _____ hrs for ____ days when directed by PCP

Other Quick Relief 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 ucg 1 puff every 4 hours PRN respiratory symptoms.

☐ Albuterol with ICS: Albuterol: 2 puffs plus Fluticasone 110 ucg _____ puffs every 4 hours PRN respiratory symptoms.

☐ Albuterol ___ puffs + ICS **(provided by parent)** Name: _____ Strength _____: ___ puffs every 4 hours PRN respiratory symptoms.

Special Instructions:

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 &_____PM

Health Care Practitioner

Last Name (Print):_____ First Name (Print): _____ ☐ 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: _____ E-mail address: _____

Tel: _____ FAX: _____ Cell Phone: _____

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

FORMS CANNOT BE COMPLETED BY A RESIDENT
INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS.

PARENTS MUST SIGN PAGE 2 →

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year 2025-2026

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

PARENTS/GUARDIANS READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse/School Based Health Center (SBHC) my child's medicine and equipment, including non-albuterol inhalers.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the Office of School Health (OSH) giving my child stock medication in the event my child's asthma medicine is not available.
   - I must **immediately** tell the school nurse/SBHC provider about any change in my child's medicine or the doctor's instructions**.**
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize OSH to provide health services to my child.These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse/SBHC provider a new MAF (whichever is earlier).
   - When this medication order expires, I will give my child's school nurse/SBHC provider a new MAF written by my child's health care practitioner. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse/ SBHC stating that I do not want my child to be examined by an OSH health care practitioner. The OSH health care practitioner may assess my child's asthma symptoms and response to prescribed asthma medicine. The OSH health care practitioner may decide if the medication orders will remain the same or need to be changed. The OSH health care practitioner may fill out a new MAF so my child can continue to receive health services through the OSH medical team. My health care practitioner or the OSH health care practitioner will not need my signature to write future asthma MAFs. If the OSH health care practitioner completes a new MAF for my child, the OSH health care practitioner will attempt to inform me and my child's health care practitioner.
   - This form represents my consent and request for the asthma services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Section 504 Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

     NOTE: If you opt to use stock medication, you must send your child's asthma inhaler, epinephrine, and other approved medications with your child for a school trip day and/or an after school program. Stock medications are only for use in school by OSH staff.

FOR SELF ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school and on trips. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse/SBHC will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

Student Last Name: _____ First Name: _____ MI: _____ Date of birth: _____

School (ATS DBN/Name): _____ Borough: _____ District: ____

Parent/Guardian Name (Print): _____ Parent/Guardian's Email: _____

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Address: _____

Parent/Guardian Cell Phone: _____ Other Phone:_____

Other Emergency Contact Name/Relationship: _____

Other Emergency Contact Phone:_____

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

Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2025–2026**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle :_____ Date of Birth: _____

Sex: ☐ Male ☐ Female OSIS Number: _____ Grade: _____ Class: _____ DOE District: _____

School (include name, number, address, and borough): _____

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: _____

☐ 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)

☐ 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)

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

Name: _____ Preparation/Concentration:_____ Dose:_____ PO ☐ Q4 hours ☐ Q6 hours ☐ Q24 hours prn

Student SkillLevel (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 Name:_____ Preparation/Concentration:_____ Dose: _____ PO Q_____ hours prn

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: _____ E-mail address: _____

Tel: _____ FAX: _____ Cell Phone: _____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 3/25 **PARENTS MUST SIGN PAGE 2 ➔**

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM Provider

Medication Order Form | Office of School Health | School Year **2025–2026**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year

PARENTS/GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse/school based health center (SBHC) provider my child's medicine and equipment. I will try to give the school epinephrine pens with retractable needles.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma or epinephrine medicines are not available.
   - I must **immediately** tell the school nurse/SBHC provider about any change in my child's medicine or the health care practitioner's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse/SBHC provider a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse/SBHC provider a new MAF written by my child's health care practitioner.
   - This form represents my consent and request for the allergy services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Section 504 Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment for my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

NOTE: If you decide to use stock medication, you must send your child's epinephrine, asthma inhaler and other approved medications with your child for a school trip day and/or an after school program. Stock medications are only foruse in school by OSH staff.

SELF-ADMINISTRATION OF MEDICATION (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself, the medicine prescribed on this form in school and on trips. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse/SBHC provider will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child epinephrine if my child is temporarily unable to carry and give him or herself medicine.

Student Last Name: _____ First Name: _____ MI: _____ Date of birth: _____

School (ATS DBN/Name): _____ Borough: _____ District: ____

Parent/Guardian Name (Print): _____ Parent/Guardian's Email: _____

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Address: _____

Parent/Guardian Cell Phone: _____ Other Phone _____

Other Emergency Contact Name/Relationship: _____

Other Emergency Contact Phone: _____

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

NYC Health | Office of School Health

Diabetes Medication Administration Form

Provider Medication Order Form | School Year 2025-26

Forms submitted after June 1st may delay processing for new school year.

Please fax all DMAFs to 347-396-8932/8945

Orders written will be implemented when submitted and approved. If you wish to start order implementation in September 2025, please check here ☐

Student Last Name	First name	Date of Birth	Sex ☐M ☐F	OSIS #

School ATSDBN / Name	Address	Borough	District	Grade / Class

HEALTH CARE PROVIDER COMPLETES BELOW *[Please see 'Provider Guidelines for DMAF Completion']*

SECTION A: Diagnosis

A1. Diagnosis

Diabetes Mellitus ☐ Type 1 or ☐ Type 2 or ☐ Other: _____ Dx Date _____ / _____ / _____

A2. Recent A1c

Date _____ / _____ / _____ Result _____ . _____ %

SECTION B: Emergency Orders

B1. Severe Hypoglycemia

ADMINISTER GLUCAGON AND CALL 911

Glucagon	GVOKE	Baqsimi	Zegalogue
☐ 1mg SC/IM ☐ 0.5mg SC/IM	☐ 1mg SC/IM ☐ 0.5mg SC/IM	☐ 3mg Intranasal	☐ 0.6mg SC May repeat in 15 min PRN

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN IF bG is unknown. Turn onto left side to prevent aspiration and call 911. If more than one option is chosen, school staff will use ONE form of available glucagon unless otherwise directed.

B2. Risk for Diabetic Ketoacidosis (DKA)

CALL 911 IF POSITIVE KETONES AND VOMITING, UNABLE TO TAKE PO, ALTERED MENTAL STATUS, OR BREATHING CHANGES

Test ketones if any of the following:
- vomiting
- fever ≥ 100.5 F
- bG > _____ mg/dl for the ☐ FIRST ***OR*** ☐ SECOND time that day, ≥ 2 hrs apart

If ketones small or trace, give water, re-test ketones & bG in 2 or ____ hrs

If ketones moderate or large, give water, **call parent and endocrinologist/provider and:**
- ☐ Give insulin correction dose if ≥ 2 hrs or ____ hrs since last rapid acting insulin
- ☐ NO GYM

SECTION C: Glucose Monitoring

C1. Glucose Monitoring Times

☐ PRN
☐ Breakfast
☐ Lunch
☐ Snack
☐ Gym
☐ Dismissal
☐ No bG monitoring

C2. Continuous Glucose Monitor Use *(Must complete Section G)*

☐ Use CGM readings for glucose monitoring

☐ Use CGM readings for insulin dosing

For CGMs to be used for glucose monitoring and/or insulin dosing, devices must be FDA approved for use and age and used within the limits of the manufacturer's protocol.

SECTION D: Skill Level (*If incomplete or attestation not initialed, default is nurse dependent*)

D1. Glucose Monitoring	D2. Insulin Calculation & Administration	Skill Level: Skills include finger sticks, glucometer and/or CGM use, insulin dose calculation, and insulin administration (only nurses or supervised/independent students may calculate/administer insulin)
☐	☐	**Nurse-Dependent:** Nurse or trained staff must perform
☐	☐	**Supervised:** Student to perform with adult supervision
☐	☐	**Independent:** Student carries supplies & self-administers
_____ Provider Initials		**FOR INDEPENDENT MEDICATION ADMINISTRATION: I attest that the independent student** demonstrated ability to self-carry & self-administer the prescribed medication (excluding glucagon) effectively during school, field trips, and school sponsored events.

SECTION E: Glucose Monitoring Parameters

E1. Hypoglycemia (*Provide additional hypoglycemia instructions in Section I: Other Orders*)

E1a. Oral Hypoglycemia Treatment

☐ For bG < 70 mg/dl or < _____ mg/dl, give 15 g or ____ g rapid carbs at PRN and ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ Dismissal
Recheck bG in 15 min or ____ min until bG > 70 mg/dl or _____ mg/dl

☐ For bG < _____ mg/dl, give ____ g rapid carbs at ☐ PRN ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ Dismissal
Recheck bG in 15 min or ____ min until bG > _____ mg/dl

E1b. Pre-Gym Hypoglycemia Orders

☐ For bG < _____ mg/dl, no gym
☐ For bG < _____ mg/dl, treat hypoglycemia then give uncovered snack*
☐ For bG < _____ mg/dl, give uncovered snack*

E1c. Pre-Dismissal Hypoglycemia Orders

☐ For bG < _____ mg/dl, treat hypoglycemia PRN, and give ____ g carb snack before dismissed
☐ For bG < _____ mg/dl, treat hypoglycemia PRN, call parent to pick up

15 g rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz juice

*Snacks provided by staff will be between 15-25 g carbs unless otherwise specified in Section I: Other Orders

E2. Hyperglycemia

☐ For bG > _____ mg/dl pre-gym, ☐ no gym and ☐ check ketones (no gym applies regardless of ketones, for ketone parameters, see Section B2)
☐ For bG > _____ mg/dl PRN, give insulin correction if ≥ 2 hrs or ____ hrs since last rapid acting insulin

bG "HI" reading = 500 mg/dl or _____ mg/dl

SECTION F: Insulin Orders

F1. Insulin Name

_____ ☐ No insulin in school

** May substitute Novolog with Admelog/Humalog*

F2. Insulin Delivery Method

☐ Syringe/Pen ☐ Smart Pen - use pen suggestions
☐ Pump (Brand) **If left blank, will use syringe/pen*

_____
**For iLet, must complete iLet Pump Orders Form*

F3. Insulin Pump Orders

☐ Student on FDA approved hybrid closed loop pump – basal rate variable per pump
☐ Follow pump recommendations for bolus doses
☐ Suspend/disconnect pump for hypoglycemia not responding to treatment for _____ min
☐ Suspend/disconnect pump for gym
☐ Activity Mode: Start 60 min or ____ min prior to exercise until 120 min or ____ min after exercise

F4. Concern for Pump Failure/Pump Dislodgement

☐ For bG > _____ mg/dl that has not decreased in ____ hrs after correction, consider pump failure and notify parents
☐ For suspected pump failure/dislodgement, SUSPEND pump and give rapid acting insulin by syringe/pen
☐ For pump failure/dislodgement, only give correction dose if > ____ hrs since last rapid acting insulin
☐ In the setting of pump failure/dislodgement, do not use the pump to calculate insulin correction doses

F5. Insulin Calculation Methods

F5a. Correction Dose Using: ☐ ISF ☐ Sliding Scale

F5b. Carb Coverage Using: ☐ I:C ☐ Sliding Scale ☐ Fixed Dose

F5c. Insulin Dosing for Meals:

	Meal		
Insulin Dose	Breakfast	Lunch	Snack
Carb Coverage Dose	☐	☐	☐
Correction Dose	☐	☐	☐

When carb coverage and correction doses are given at the same time, correction dose will be added when bG > target ***and*** ≥ 2 hrs or ____ hrs since last rapid acting insulin unless otherwise specified

F5d. Exceptions to Pre-Food Insulin Administration

☐ If bG> _____ mg/dl, give correction dose pre-meal and carb coverage after meal
☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

Carb Coverage using I:C

$\frac{\text{\# g carb in meal}}{\text{I:C}}$ = X units insulin

Correction using ISF

$\frac{\text{bG – target bG}}{\text{ISF}}$ = Y units insulin

Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have ½ unit marks unless otherwise instructed by PCP/Endocrinologist. **Round DOWN** to nearest 0.1 unit for pumps unless following pump recommendations or PCP/Endocrinologist orders.

F6. Insulin Dose Calculation Ratios

Times will be 7am – 4pm if not specified

F6a. Target bG

_____ mg/dl from time _____ to _____

_____ mg/dl from time _____ to _____

F6b. Insulin Sensitivity Factor (ISF)

1 unit decreases bG by:

_____ mg/dl from time _____ to _____

_____ mg/dl from time _____ to _____

F6c. Insulin:Carb Ratio (I:C)

Time _____ to _____ ***OR*** Breakfast
1 unit per ____ g carbs

Time _____ to _____ ***OR*** Lunch
1 unit per _____ g carbs

Time _____ to _____ ***OR*** Snack
1 unit per ____ g carbs

☐ If gym/recess is immediately following meal, subtract ____ g carbs from meal carb calculation

Student Last Name	First name	Date of Birth	OSIS #

SECTION F: Insulin Orders (Continued)

F7. Sliding Scales (*Provide additional sliding scales in Section I: Other Orders*)

Do **NOT** overlap ranges (e.g., enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. You must provide a range from 0 to "high" bG, which is 500 mg/dl unless otherwise specified in Section E2: Hyperglycemia. Use pre-treatment bG to calculate insulin dose unless specified in Section I: Other Orders.

F7a. Correction Dose

bG (mg/dl)	Units
Zero -	0
-	
-	
-	
-	
-	
-	

F7b. Carb Coverage *PLUS* Correction Dose

bG (mg/dl)	Units	Use For:
Zero -		☐ Breakfast
-		☐ Lunch
-		☐ Snack
-		☐ See attached
-		
-		
-		

F8. Fixed Dosing for Carb Coverage

Correct bG using method in Section F5a: Correction Dose and for carb coverage ADD:
- ☐ ____ units for breakfast
- ☐ ____ units for lunch
- ☐ ____ units for snack

F9. Alternate Rounding Instructions
- ☐ Round insulin dosing to nearest whole unit: 0.50-1.49u rounds to 1u
- ☐ For half unit pen/syringe, round insulin dosing to nearest half unit: 0.25-0.74u rounds to 0.5u

F10. Long-Acting Insulin
- ☐ Give long-acting insulin at school
  - Name: _____
  - Dose: ____ units
  - Time: _____ ***OR*** pre-lunch
  - Long-acting insulin may be given at the same time as rapid-acting insulin at a different injection site (e.g., different arms)

SECTION G: Continuous Glucose Monitoring (CGM) Orders *[Please see 'Provider Guidelines for DMAF Completion']*

G1. Name and Model of CGM: _____

For CGMs to be used for glucose monitoring and/or insulin dosing, devices must be FDA approved for use and age and used within the limits of the manufacturer's protocol and in accordance with manufacturer's instructions. For CGM used for insulin dosing, finger stick bG will be done when symptoms don't match the CGM readings or if there is some reason to doubt the sensor (i.e. for readings < 70 mg/dl or sensor does not show both arrows and numbers). For sG < 70mg/dl, check bG and follow hypoglycemia orders on DMAF, unless otherwise ordered below.

G2. CGM Instructions: Use CGM grid below ***OR*** ☐ see attached CGM instructions.

CGM Reading	**Arrows**	**Action** ☐ **use < 80 mg/dl instead of < 70 mg/dl for grid action plan**
sG < 60 mg/dl	Any arrows	Treat hypoglycemia per bG hypoglycemia plan. Recheck in 15-20 min. If sG still < 70 mg/dl, check bG.
sG 60-69 mg/dl	↓, ↓↓, ↘ or →	Treat hypoglycemia per bG hypoglycemia plan. Recheck in 15-20 min. If sG still < 70 mg/dl, check bG.
sG 60-69 mg/dl	↑, ↑↑, or ↗	If symptomatic, treat hypoglycemia per bG hypoglycemia plan. If asymptomatic, recheck in 15-20 min. If sG still <70 mg/dl, check bG.
sG ≥ 70 mg/dl	Any arrows	Follow bG DMAF orders for insulin dosing.
sG ≤ 120 mg/dl pre-gym or recess	↓, ↓↓	Give 15 g uncovered carbs. If gym or recess is immediately after lunch, subtract 15 g of carbs from lunch carb calculation.
sG ≥ 250 mg/dl	Any arrows	Follow bG DMAF orders for treatment and insulin dosing.

☐ For student using CGM, wait 2 hours after a meal before testing for ketones with hyperglycemia

SECTION H: Parental Input into Dosing

Parent(s)/Guardian(s) (**MUST GIVE NAME**), _____, may provide the nurse with information relevant to insulin dosing, including dosing recommendations. Taking the parent's input into account, the nurse will determine the insulin dose within the range ordered by the health care provider and in keeping with nursing judgement.

SELECT ONE

☐ Nurse may adjust calculated dose up or down up to ____ units based on parental input and nursing judgement.

☐ Nurse may adjust calculated dose up by ____ % or down by ____ % of the prescribed dose based on parental input and nursing judgement.

MUST COMPLETE: Health care provider can be reached for urgent dosing orders at (_____) _____- _____. If the parent requests a similar adjustment for > 2 days in a row, the nurse will contact the health care provider to see if the school orders need to be revised.

SECTION I: Other Orders

SECTION J: Home Medications

Medication	Dose	Route	Frequency	Time

SECTION K: Additional Information

Is the child using altered or non-FDA approved equipment? ☐ **Yes** ☐ **No** [*Please note that New York State Education laws prohibit nurses from managing non-FDA approved devices. For nurse to administer insulin at school, you must provide pump failure and/or back up orders on DMAF page 1.*]

By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s).

Health Care Provider Last Name (PLEASE PRINT)	First name	**Signature**	**Date**

Credentials: ☐ MD ☐ DO ☐ NP ☐ PA

Address Street	City/State	ZIP	**Email**

NYS License # or NPI # (Required)	Tel	Fax	CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.

Office of
School Health

Forms submitted after June 1st may delay processing for new school year.

Diabetes Medication Administration Form
Parent Consent Form | School Year 2025-26
Please fax all DMAFs to 347-396-8932/8945

Student Last Name	First name	Date of Birth	Sex ☐M ☐F	OSIS #

School ATSDBN / Name	Address	Borough	District	Grade / Class

PARENTS AND GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to the nurse/school-based health center (SBHC) provider giving my child's prescribed medicine, and the nurse/trained staff/SBHC provider checking their blood sugar and treating their low blood sugar based on the directions and skill level determined by my child's health care provider. These actions may be performed on school grounds or during school trips.
2. I also consent to any equipment needed for my child's medicine being stored and used at school.
3. I understand that:
   - I must give the school nurse/SBHC provider my child's medicine, snacks, equipment, and supplies and must replace such medicine, snacks, equipment and supplies as needed. The Office of School Health (OSH) recommends the use of safety lancets and other safety needle devices and supplies to check my child's blood sugar levels and give insulin.
   - I consent to my child carrying and storing their medication/supplies in school and on trips as outlined in their 504 meeting.
   - All prescription and "over the counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.
     - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: **1)** my child's name, **2)** pharmacy name and phone number, **3)** my child's health care provider's name, **4)** date, **5)** number of refills, **6)** name of medicine, **7)** dosage, **8)** when to take the medicine, **9)** how to take the medicine and **10)** any other directions.
   - I must **immediately** tell the school nurse/SBHC provider about any change in my child's medicine or the health care provider's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this Medication Administration Form (MAF), I authorize OSH to provide diabetes-related health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care provider or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse/SBHC provider a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse/ SBHC provider a new MAF written by my child's health care provider.
   - OSH and the Department of Education (DOE) make sure that my child can safely test their blood sugar.
   - This form represents my consent and request for the diabetes services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment for my child, OSH may obtain any other information they think is needed about my child's medical condition, medication, or treatment. OSH may obtain this information from any health care provider, nurse, or pharmacist who has given my child health services.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

OSH Parent Hotline for questions about the Diabetes Medication Administration Form (DMAF): 718-786-4933

FOR SELF-ADMINISTRATION OF MEDICINE AND/OR PROCEDURES (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine and/or perform procedures on their own. I consent to my child carrying, storing, and giving themself the medicine prescribed on this form in school and on trips. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use and for all results of my child's use of this medicine in school. The school nurse or SBHC providers will confirm my child's ability to carry and give themself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child glucagon if prescribed by their health care provider if my child is temporarily unable to carry and take medicine.

PARENT / GUARDIAN SIGN BELOW		
Print Parent / Guardian's Name	**Parent / Guardian's Signature for Parts A & B**	**Date Signed**

Parent / Guardian's Address		Parent / Guardian's Email	
Emergency Contact Numbers	Best Contact Tel No.	Home Tel No.	Cell Phone No.
Alternate Emergency Contact's Name		Relationship to Student	Contact Tel No.

Diabetes Medication Administration Form

Provider Medication Order Form | School Year 2025-26

Please fax all DMAFs to 347-396-8932/8945

For Office of School Health (OSH) Use Only

OSIS Number:

Received by: Name Date:_____/_____/_____

Reviewed by: Name Date:_____/_____/_____

☐504 ☐IEP ☐Other 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 as per OSH contact with prescribing health care practitioner

☐ **Clarified** ☐ **Modified**

Notes

Attach student photo here

MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION) FORM Provider

Treatment Order Form | Office of School Health | School Year **2025-2026**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female OSIS Number: _____ Grade: _____ Class: _____ DOE District: _____

School (include ATSDBN/name, address, and borough):_____

HEALTHCARE PRACTITIONERS COMPLETE BELOW

ONE ORDER PER FORM (make copies of this from for additional orders). Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization.

- ☐ Blood Pressure Monitoring
- ☐ Chest Clapping/Percussion
- ☐ Clean Intermittent Catheterization: Cath Size _____ Fr.
- ☐ Central Line/PICC Line
- ☐ Dressing Change
- ☐ Feeding: Cath Size _____ Fr.
  - ☐ Nasogastric ☐ G-Tube ☐ J-Tube
  - ☐ Bolus ☐ Pump ☐ Gravity ☐ Spec./Non-Standard*
- ☐ Feeding Tube replacement if dislodged - specify in #5
- ☐ Oral / Pharyngeal Suctioning: Cath Size _____ Fr.
- ☐ Ostomy Care
- ☐ Oxygen Administration - specify in #1, including pulse oximetry
- ☐ Postural Drainage
- ☐ Pulse Oximetry - specify in #1
- ☐ Trach Care: Trach. Size _____
- ☐ Trach Replacement - specify in #5
- ☐ Trach suctioning: Cath Size ___Fr
- ☐ Other: _____

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 (initial below)

☐ _____ **Practitioner's initials** I attest student demonstrated the ability to self-administer the prescribed treatment effectively during school, field trips, and school-sponsored events

Diagnosis: _____ Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS)

Diagnosis is self- limited: ☐Yes ☐ No ☐ ____._____ ☐ ____._____ ☐____._____

1. Treatment required in school:

☐ **Feeding**: Formula Name: _____ Concentration: _____

Route: _____ Amount:_____ Rate: _____ Duration: _____ Frequency/specific time(s) of administration: _____

***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.**

☐ **Flush** with _____ mL _____ ☐ Before feeding ☐ After feeding

☐ **Oxygen Administration**: Amount (L): _____ Route: _____ Frequency/specific time(s) of administration: _____

☐ prn ☐ 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: _____ E-mail address: _____

Tel: _____ Fax: _____ Cell Phone: _____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS - FORMS CANNOT BE COMPLETED BY A RESIDENT Rev 3/25 PARENTS MUST SIGN PAGE 2 →

MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment Order Form | Office of School Health | School Year **2025–2026**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

PARENT/GUARDIAN READ, COMPLETE, AND SIGN: BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medical supplies, equipment and prescribed treatments being stored and given at school based on directions from my child's health care practitioner.
2. I understand that:
   - I must give the school nurse/school based health center (SBHC) provider my child's medical supplies, equipment and treatments.
   - **All supplies I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired supplies for my child's use during school days.**
     - Supplies, equipment and treatments should be labeled with my child's name and date of birth.
   - I must **immediately** tell the school nurse/SBHC provider about any change in my child's treatments or the health care practitioner's instructions.
   - The Office of School Health (OSH) and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this form, I authorize OSH to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The treatment instructions/orders on this form expire at the end of my child's school year, which may include the summer session, or when I give the school nurse a new form (whichever is earlier). When this medication order expires, I will give my child's school nurse/ SBHC provider a new MAF written by my child's health care practitioner.
   - This form represents my consent and request for the medical services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Section 504 Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication, or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

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.

FOR SELF-TREATMENT (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can perform treatments on his or her own. I consent to my child carrying, storing and giving him or herself, the treatments prescribed on this form in school and on trips. I am responsible for giving my child these supplies and equipment labeled as described above. I am also responsible for monitoring my child's treatments, and for all results of my child's self-treatment in school. The school nurse/SBHC provider will confirm my child's ability to perform treatments on his/her own. I also agree to give the school clearly labeled "back up" equipment or supplies in the event that my child is unable to self-treat.

Student Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

SchoolATSDBN/Name: _____

Borough: _____ District: _____

Parent/Guardian's Email: _____ **Parent/Guardian's Address:** _____

Telephone Numbers: Daytime: _____ Home: _____ Cell Phone*: _____

Parent/Guardian's Name: _____ **Parent/Guardian's Signature:** _____

Date Signed: _____

Alternate Emergency Contact:

Name: _____ Relationship to Student: _____ Contact Number: _____

FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

OSIS Number: _____

Received by: Name: _____ Date: _____ Reviewed by: _____ Date: _____

☐ 504 ☐ IEP ☐ Other 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 as per OSH contact with prescribing health care practitioner: ☐ Clarified ☐ Modified

MEDICAL ACCOMMODATIONS REQUEST FORM

Office of School Health | School Year 2025-2026

Student's health care practitioner completes this form, and parent submits it to the 504 Coordinator or IEP team with attached: Request for Health Services/Section 504 Accommodations Parent Form with HIPAA Authorization (for new or modified requests), Medication Administration Form (MAF) and/or Medically Prescribed Treatment Form, and any additional supporting documentation from practitioner/provider.

Student Name: _____ *OSIS #:* _____ *Student's Date of Birth:* _____

☐ 504 Request ☐ IEP Request IEP Classification: _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

MEDICAL INTERVENTION

Medical Diagnosis _____ /ICD-10 Code/DSM-V Code(s): _____._____ _____._____ _____._____

If the request is for a diagnosis of allergies/anaphylaxis, diabetes, or seizure disorder, please complete the Medical Accommodations Request Form Addendum.

This condition is: ☐ Acute ☐ Chronic Expected duration of accommodation: _____ weeks

Request for: ☐ nursing services ☐ paraprofessional support ☐ transportation ☐ other (see Other Services)

Requests for nursing or paraprofessional support, will be reviewed on a case-by-case basis to determine whether the student needs 1:1 support or school-based support. When a student requires medication during the school day and is unable to self-administer, medication is generally administered by the school nurse. Trained paraprofessionals may administer epinephrine and glucagon; all other medications, including insulin, must be administered by a nurse. Requests for transportation accommodations will be reviewed on a case-by-case basis. Prior to commencement of services, MAFs must be submitted for all medications, supervision, and monitoring, and Medically prescribed Treatment Forms submitted for clinical procedures performed by OSH and its agents during school hours or DOE programs or activities.

Student's current clinical status *(level of control, current management plan, pending evaluations, etc.)*:

Type of Medical Intervention:	Intervention Needed
☐ Administration of Medications Please complete and submit all applicable Medication Administration Forms (MAFs: Allergy & Anaphylaxis, Asthma, Diabetes, General, Seizure). ☐ Emergency Medications (e.g. glucagon, rectal diazepam) Please list all emergency medications, including time frame for administration Will student require daily administration of medication during school hours? ◯ Yes ◯ No Will student require in-school medications 3 or more times per day? List daily medications here, and attach MAFs. ◯ Yes ◯ No	☐ during school ☐ during transport
☐ Procedures and Treatments, Routine and Emergency *(e.g., suctioning, airway management, vagal nerve stimulator) Please complete and submit the Request for Provision of Medically Prescribed Treatment Form (Non-Medication)* *Please list, including timing and frequency of administration during the school day.*	☐ during school ☐ during transport
☐ Equipment Management *(e.g., ventilator, oxygen) Please complete the Request for Provision of Medically Prescribed Treatment Form (Non-Medication)* Please list all equipment that will accompany the student during school and/or transport:	☐ during school ☐ during transport
☐ Other Services *Please complete all appropriate forms (MAFs, Request for Provision of Medically Prescribed Treatment Form, if applicable)* ☐ air conditioning ☐ ambulation assistance ☐ elevator pass ☐ other Please list:	☐ during school ☐ during transport

PROVIDERS, PLEASE SIGN PAGE 2 →

MEDICAL ACCOMMODATIONS REQUEST FORM
Office of School Health | School Year 2025-2026

STUDENT CONSIDERATIONS

Supervision/Monitoring Required: ☐ none ☐ during school ☐ during transport

Supervision/Monitoring Frequency: ☐ continuous ☐ other

Please describe the additional supervision/monitoring needed, including the tasks/responsibilities:

Is the student considered to be medically unstable (At risk for medical decompensation during school or transport)?

☐ Yes (please describe below) ☐ No

Is the student considered to be behaviorally unstable (poses a danger to themself or to other students)?

☐ Yes (please describe below) ☐ No

Does the student currently utilize the following: ☐ Crutches ☐ Cast ☐ Wheelchair ☐ Walker ☐ Other: _____

Please list any other clinical concerns relevant to supporting the student during the school day and/or during transport (Attach additional information if needed)

How does this diagnosis affect educational performance? Does the diagnosis have an impact on learning, participation, or attendance in school? If so, please describe.

CONTACT INFORMATION & ATTESTATION

Phone number - Office: _____ Cell: _____ Email: _____

Best days to be reached:

☐ Mon-Time: _____ ☐ Tue-Time: _____ ☐ Wed-Time: _____ ☐ Thu-Time: _____ ☐ Fri -Time: _____

I attest that I have provided clinical services to this student and that the information above is complete and clinically accurate as of the date provided below.

Provider's Name (print): _____ License #: _____

Provider's Signature: _____ Date of completion: _____

MEDICAL ACCOMMODATIONS REQUEST FORM ADDENDUM 2025-2026

To Completed by the Student's Health Care Practitioner

Student Name: _____ DOB: _____ Student ID#: _____

Allergies/Anaphylaxis

(Note Available School-Specific Allergy Resources listed below)

List allergen(s): _____

Source of allergy documentation: ☐ Skin Testing ☐ Blood Test ☐ Parental Report

History of Anaphylaxis? ◯ Yes ◯ No

If yes, specify system(s) affected: ☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic Medications

Medications: _____

Was an **Allergy/Anaphylaxis** MAF completed? ◯ Yes ◯ No

Does the student have a history of developmental or cognitive delay? ◯ Yes ◯ No

If yes, specify diagnosis/diagnoses: _____

Does the student have prior experience with self-monitoring? ◯ Yes ◯ No

Can the student:

- ☐ Independently self-monitor and self-manage?
- ☐ Recognize symptoms of an allergic reaction?
- ☐ Promptly inform an adult as soon as accidental exposure occurs or symptoms appear, or ask a friend for help?
- ☐ Follow safety measures established by a parent/guardian and/or school team?
- ☐ Understand not to trade or share foods with anyone?
- ☐ Understand not to eat any food item that has not come from or been approved by a parent/guardian?
- ☐ Wash hands before and after eating?
- ☐ Develop a relationship with the school nurse or another trusted adult in the school to assist with the successful management of allergy in the school?
- ☐ Carry an epinephrine auto-injector?

Provider Signature: _____

Diabetes

When was the student diagnosed with diabetes? _____

Was a **Diabetes MAF** completed for this student? ◯ Yes ◯ No

Does the student have any cognitive challenges or physical disabilities that interfere with the student providing self-care for their diabetes? ◯ Yes ◯ No

If yes, please specify: _____

Can the student identify symptoms of hypoglycemia? ◯ Yes ◯ No

Can the student notify an adult when they feel that their blood glucose is not normal? ◯ Yes ◯ No

What is the plan to transition the student to independent functioning? _____

Provider Signature: _____

Seizure Disorder

Type of Seizure: _____

Frequency of Seizures _____

Medication(s), including emergency medications: _____

Was a **Seizure MAF** Completed? ◯ Yes ◯ No

Are the seizures well-controlled by the current medication regimen? ◯ Yes ◯ No

Does the student require routine or prn emergency medication in school? ◯ Yes ◯ No

If yes, has an MAF been completed? ◯ Yes ◯ No

Other associated signs and symptoms, including medication side effects: _____

Number of seizure-related ER visits during the past year: _____

Number of seizure-related hospitalizations/ICU admissions: _____

Frequency of office visits/monitoring: _____ ◯ Weeks ◯ Months

Last Office Visit: _____

Activity Restrictions: _____

Provider Signature: _____

DO NOT WRITE BELOW - SCHOOL USE ONLY

School-Specific Allergy Resources:

- ☐ Allergy Table(s) in the lunchroom: _____ staff members for supervision
- ☐ Allergy Table(s) in the classroom: _____ staff members for supervision
- ☐ General Staff Training for Epinephrine administration: _____ staff members trained
- ☐ Student-Specific Training for Epinephrine administration: _____ staff members trained
- ☐ Allergy Response Plan received from school nurse
- ☐ Other: _____

School-Specific Diabetes Resources:

- ☐ General Diabetes Basics Staff Training
- ☐ Student-Specific Staff Training for Glucagon administration
- ☐ Diabetes Care Plan from school nurse
- ☐ Other: _____

Name of Principal or Principal's Designee: _____

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV/AIDS* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 7. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 7, I specifically authorize release of such information to the New York City Department of Health and Mental Hygiene ("DOHMH") and the New York City Department of Education ("DOE"), which jointly operate the Office of School Health.
2. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, DOHMH is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of the people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care providers I have authorized to release my information. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization may be redisclosed by DOHMH or DOE (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMATION WITH, THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE NEW YORK CITY DEPARTMENT OF EDUCATION**.

7. Specific information to be released and discussed:

All health information (written and oral) including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to my health care providers by other health care providers.

☐ If this box is checked, release and discuss only health information specified here:_____

(*Use this box if you do not want the entire record released or disclosed. Use box 9 below to set how long you want this form to last*)

Include: (*Indicate by Initialing*)

_____Alcohol/Drug Treatment Information. ***Specify records to be released and releasing organization:*** **_____**

_____Mental Health Information

_____HIV/AIDS-Related Information

8. **REASON FOR RELEASE OF INFORMATION: THIS INFORMATION IS RELEASED AT REQUEST OF THE PATIENT OR REPRESENTATIVE, UNLESS OTHERWISE SPECIFIED HERE:**	9. **THIS AUTHORIZATION EXPIRES ON THE DATE THAT PATIENT IS NO LONGER ENROLLED IN A SCHOOL OR PROGRAM OPERATED BY DOE OR SERVICED BY THE OFFICE OF SCHOOL HEALTH, UNLESS OTHERWISE SPECIFIED HERE**:**
10. **IF NOT THE PATIENT, NAME OF PERSON SIGNING FORM: (PARENT/GUARDIAN MUST COMPLETE)**	11. **THE PERSON SIGNING THIS FORM IS AUTHORIZED BY LAW TO SIGN ON BEHALF OF THE PATIENT AS THE PARENT OR LEGAL GUARDIAN OF THE PATIENT, OR AS SPECIFIED HERE:**

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

****If an expiration date is specified in item 9 above, the form will expire on that date and a new form must be submitted by the parent or legal guardian of the patient, or other persons authorized by law**.

REQUEST FOR HEALTH SERVICES/SECTION 504 ACCOMMODATIONS PARENT FORM 2024-2025

Name of Student _____ DOB _____ Student ID# _____

School Name _____ School ATS/DBN _____ Grade/Class _____

Name of Requesting Parent/Guardian _____ Relationship to Student _____

Date Submitted to the 504 Coordinator _____ Name of 504 Coordinator _____

Does the student have a current IEP? ☐ Yes ☐ No 504 Coordinator Email _____

Parent/Guardian must complete entire form and submit to the school's 504 Coordinator or IEP team.

Part 1: Reason for requesting accommodations *(Describe the concern below and how it affects the student's performance at school):*

Request accommodations based on the concerns listed above. Please contact your school's 504 Coordinator or IEP team with any questions.

Request for Accommodation(s) *Guardian Checks all requested:*	**New Request, or Modification** *For school use only*	**Renewal without Modification** *For school use only*
Testing Accommodations ☐ Test schedule/administration time (e.g., extended time) ☐ Test setting/location ☐ Method of presentation/Directions/Assistive Technology ☐ Method of test response/content support ☐ Other (please specify)	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Classroom / Curriculum Accommodations ☐ Class schedule/use of time ☐ Class activities setting ☐ Method of presentation/Directions/Assistive Technology ☐ Method of class activities response/Content Support ☐ Other (please specify)	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Health Supports Paraprofessional ☐ 1:1 ☐ Other Nursing Services (Submit MAF to School Nurse) ☐ 1:1 ☐ School Nurse	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐
Transportation ☐ Transportation for a long-term or chronic condition (If requesting transportation for a temporary medical condition **or** short-term limited mobility, submit the Medical Exception Request to **busingexceptions@schools.nyc.gov** instead of submitting this Parent Request form)	☐	☐
Other Services ☐ Safety Net (high school only) ☐ Other (please specify) _____	☐ ☐	☐ ☐

When a student requires medication during the school day and is unable to self-administer, medication is generally administered by the school nurse; the Medication Administration Form must be submitted to the school nurse. Requests for 1:1 nursing, paraprofessional support, and transportation will be reviewed on a case-by-case basis by an Office of School Health (OSH) Practitioner to confirm that services are medically needed. Decisions about whether a student requires a particular accommodation are made by the 504 Team or IEP team, which includes the parent. Additional forms must be completed; please check with your 504 Coordinator or IEP team. The New York City Department of Education (DOE) will review Assistive Technology requests and may facilitate an evaluation to determine the student's needs.

Part 2: PARENT CONSENT – Parent/Guardian must complete before submitting to your school's 504 Coordinator or IEP team

Your child may qualify for accommodations under Section 504 of The Rehabilitation Act of 1973. Your school's 504 team and/or IEP team will meet to review your child's records, classwork, classroom observations, testing, and health care practitioner's statement. If your child qualifies for services based on that review, the team will create a 504 Plan and/or IEP with your help and consent. 504 Plans **must be reviewed before the end of each school year** or more often if necessary.

By signing this form: 1) I am giving consent to the 504 team and/or IEP team to review my child's records and decide if my child qualifies for accommodations. 2) I confirm that I have provided full and complete information to the best of my ability. 3) I understand that the OSH and the DOE are relying on the accuracy of the information on the form for their review and decisions. 4) I understand that the OSH and the DOE may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

☐ **Completed HIPAA form attached (REQUIRED FOR REVIEW. PARENTS MUST COMPLETE THE BACK OF THIS FORM)**.

Name of Parent/Guardian _____ Daytime Phone Number _____

Signature of Parent/Guardian _____ Date _____

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name	Date of Birth	Patient Identification Number/OSIS#
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV/AIDS* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 7. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 7, I specifically authorize release of such information to the New York City Department of Health and Mental Hygiene ("DOHMH") and the New York City Department of Education ("DOE"), which jointly operate the Office of School Health.
2. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, DOHMH is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of the people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (888) 392-3644 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care providers I have authorized to release my information. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization may be redisclosed by DOHMH or DOE (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMATION WITH, THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE NEW YORK CITY DEPARTMENT OF EDUCATION**.

7. Specific information to be released and discussed:

All health information (written and oral) including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to my health care providers by other health care providers.

For patients with any of the health conditions listed below, initial to authorize release of information: (*Indicate by initialing*)

_____**Alcohol/Drug Treatment Information.** ***Specify records to be released and releasing organization:*** _____

_____**Mental Health Information**

_____**HIV/AIDS-Related Information**

☐ If this box is checked, release and discuss only health information specified here:_____

(*Use this box if you do not want the entire record released or disclosed*)

8. **REASON FOR RELEASE OF INFORMATION: THIS INFORMATION IS RELEASED AT THE REQUEST OF THE PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW, UNLESS OTHERWISE SPECIFIED HERE:**	9. **THIS AUTHORIZATION WILL LAST UNTIL THE PATIENT IS NO LONGER ENROLLED IN A SCHOOL OR PROGRAM OPERATED BY DOE OR SERVICED BY THE OFFICE OF SCHOOL HEALTH, UNLESS AN EXPIRATION DATE IS LISTED HERE:**
10. **IF NOT THE PATIENT, PRINT NAME OF PERSON SIGNING FORM: (PARENT/GUARDIAN MUST COMPLETE)**	11. **RELATIONSHIP TO PATIENT:** ☐ Self ☐ Parent/Guardian ☐ Other (please describe below)

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

****If an expiration date is specified in item 9 above, the form will expire on that date and a new form must be submitted by the parent or legal guardian of the patient, or other persons authorized by law**.

Attach student photo here

SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form I Office of School Health I School Year **2025-2026**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

Student Last Name: _____ First Name: _____ Middle: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female OSIS Number: _____ Grade: _____ Class: _____ DOE District: _____

School (include name, number, address, and borough): _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis/Seizure Type:

☐ 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.):

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

TREATMENT PROTOCOL DURING SCHOOL:

A. In-School 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

B. 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
☐ diazepam				min	
☐ midazolam				min	

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) ☐ None	Dosage, Route, Directions	Side Effects/Specific Instructions

Other special instructions

Health Care Practitioner

Last Name (Print):_____ First Name: _____ (Please Check one): ☐ MD ☐ DO ☐ NP ☐ PA

Signature:_____ Date: _____ NYS License # (Required): _____ NPI #: _____

Address: _____ E-mail address:_____

Tel. No: _____ FAX No: _____ Cell Phone: _____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

Rev 3/25

PARENTS MUST SIGN PAGE 2 →

SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2025-2026**

Please return to School Nurse/School Based Health Center. Forms submitted after June 1st may delay processing for new school year.

PARENTS/GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.

2. **I understand that:**

- I must give the school nurse/school based health center (SBHC) provider my child's medicine and equipment.
- **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box.** I will get another medicine for my child to use when he or she is not in school or is on a school trip.
    - o Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
- I must **immediately** tell the school nurse/SBHC provider about any change in my child's medicine or the health care practitioner's instructions.
- **No student is allowed to carry or give him or herself controlled substances.**
- The Office of School Health (OSH) and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
- By signing this medication administration form (MAF), OSH may provide health services to my child. These services may include a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
- The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse/SBHC provider a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse/SBHC provider a new MAF written by my child's health care practitioner.
- This form represents my consent and request for the medication services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Section 504 Accommodation Plan. This plan will be completed by the school.
- OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.
- I understand that emergency seizure medications, including intranasal medications, can only be administered by a nurse or other licensed medical provider according to New York State regulations.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

FOR SELF-ADMINISTRATION OF NON-EMERGENCY MEDICATIONS (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school and on trips. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse or SBHC provider will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

Student Last Name: _____ First Name: _____ MI: _____ Date of birth: _____

School Name/Number: _____ Borough: _____ District: _____

Parent/Guardian Name (Print): _____ Parent/Guardian's Email: _____

Parent/Guardian Signature: _____ Date Signed: _____

Parent/Guardian Address: _____

Telephone Numbers: Daytime: _____ Home_____ Cell Phone: _____

Alternate Emergency Contact:

Name: _____ Relationship to Student: _____ Phone Number:_____

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 as per OSH contact with prescribing health care practitioner: ☐ Clarified ☐ Modified

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NYC Public Schools

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DIVISION OF INCLUSIVE AND ACCESSIBLE LEARNING
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