



REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment Order Form | Office of School Health | School Year **2020-2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name _____	First Name _____	Middle _____	Date of birth ____/____/____ MM DD YYYY	<input type="checkbox"/> Male	<input type="checkbox"/> Female
OSIS Number _____					
School (include ATSDBN/name, address and borough)		DOE District	Grade	Class	

HEALTHCARE PRACTITIONERS COMPLETE BELOW

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

<input type="checkbox"/> Clean Intermittent Catheterization Cath Size ____Fr.	<input type="checkbox"/> Tracheostomy Care Trach. Size ____.	<input type="checkbox"/> Ostomy Care
<input type="checkbox"/> Central Venous Line	<input type="checkbox"/> Trach. suctioning Cath. Size ____Fr.	<input type="checkbox"/> Chest Clapping
<input type="checkbox"/> G-Tube Feeding*: <input type="checkbox"/> Bolus <input type="checkbox"/> Pump <input type="checkbox"/> Gravity Cath Size ____Fr.	<input type="checkbox"/> Trach replacement - specify in area below	<input type="checkbox"/> Percussion
<input type="checkbox"/> J-Tube Feeding*: <input type="checkbox"/> Bolus <input type="checkbox"/> Pump <input type="checkbox"/> Gravity Cath Size ____Fr.	<input type="checkbox"/> Oxygen Administration - specify in area below	<input type="checkbox"/> Postural Drainage
<input type="checkbox"/> Naso-Gastric Feeding* Cath Size ____Fr.	<input type="checkbox"/> Pulse Oximetry monitoring	<input type="checkbox"/> Dressing Change
<input type="checkbox"/> Specialized/Non-Standard Feeding* Cath Size ____Fr.	<input type="checkbox"/> Vagus Nerve Stimulator	
<input type="checkbox"/> Feeding Tube replacement if dislodged - specify in area below	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Oral / Pharyngeal Suctioning Cath Size ____Fr.		

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)

I attest student demonstrated the ability to self-administer the prescribed treatment effectively for school/field trips/school-sponsored events

Practitioner's initials

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

Diagnosis is self-limited Yes No

2. Treatment required in school:

Feeding: _____
Formula Name _____ Concentration _____ Route _____ Amount/Rate _____ Duration _____ Frequency/specific time(s) of administration _____

* Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. 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: _____ _____ prn O2 Sat < ____% _____
Amount (L) Route Frequency/specific time(s) of administration Specify Symptoms

Other Treatment: _____ _____ prn _____
Treatment Name Route Frequency/specific time(s) of administration Specify Symptoms

Additional Instructions or Treatment: _____

3. Conditions under which treatment should not be provided: _____

4. Possible side effects/adverse reactions to treatment: _____

5. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions, including dislodgement or blockage of tracheostomy or feeding tube: _____

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

7. Date(s) when treatment should be: Initiated ____/____/____ Terminated ____/____/____

Health Care Practitioner Please Print and select one: MD DO NP PA	LAST NAME _____	FIRST NAME _____	Signature _____
Address _____	Tel. No. (____) _____ - _____		Fax. No (____) _____ - _____
E-mail address _____	Cell phone (____) _____ - _____		
NYS License No (Required) _____	NPI No. _____	Date ____/____/____	

