

천식약 투약 양식

의료제공자 투약 지시 양식| 학교 보건 담당실 | 2022-2023 학년도

학교 간호사에게 제출하십시오. 6월 1일 이후 제출된 양식은 새 학년도 처리가 지연될 수 있습니다.

~	학생 성:		_ 이름:		_ 중간 이	니셜:		생년월일: _	
		OSIS 번호:							
		 DBN/이름, 주소 및 5							
	HEA	LTH CARE PRACTIT	IONERS COMPLI	ETE BELOW / 의	료 보건 담	당자가 다	 음을	작성하십시오	
Diagn				l (see NAEPP G					NAEPP Guidelines)
□ Asthma			□ We	☐ Well Controlled				☐ Intermittent	
☐ Other:				□ Not Controlled / Poorly Controlled				☐ Mild Persistent	
			□ Un	known				☐ Moderate F	
		Student Asthm	a Risk Assessme	nt Questionnair	o (V = Vos	N = No	11 = 11:	☐ Severe Per	sistent
Histor	v of near-death asthm	na requiring mechanica			-		□ U	ikiiowiij	
	•	. •					□U		
History of life-threatening asthma (loss of consciousness or hy History of asthma-related PICU admissions (ever)			* *	,			_ U		
	ved oral steroids withi	` ,					□U	times	last:
		R visits within past 12	months		Y [□U		last:
	•	ospitalizations within p			Y [N	□U		last:
Histor	y of food allergy or ec	zema, specify:			Y 🗆] N	□U		
		Stud	lent Skill Level (select the mos	appropri	ate opti	on):		
	Nurse-Dependent St	udent: nurse must adr	,		•	•	•		
	·	student self-administe							
	•	t: student is self-carry/							
	□ I attest stud	ent demonstrated abili	ity to self-administ	er the prescribed					
		effectively during scho	•	•		Practitio	ner's li	nitials:	
			Quick Re	lief In-School N	ledication	1			
	Albuterol [Only gen	eric Albuterol MDI is p	rovided by school	for shared usage	·]				
	(plus individual space	er): 🗆 Stock 🗆 Par	ont Drovided						
			eni Provided	□ MDI v	v/ spacer	□ DPI			
	Standard Order:	Give 2 puffs q 4 hrs.			•		thing o	r shortness of b	reath.
	Standard Order:	Give 2 puffs q 4 hrs. Monitor for 20 mins of	PRN for coughing	, wheezing, tight	chest, diffic	ulty brea			reath.
			PRN for coughing or until symptom-fr	, wheezing, tight ee. If not sympto	chest, difficent	culty brea in 20 min	s may		reath.
	If in Respiratory Di	Monitor for 20 mins of	PRN for coughing or until symptom-fr give 6 puffs; may r	, wheezing, tight ee. If not sympto	chest, difficent	culty brea in 20 min	s may		reath.
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학부모는 반드시 페이지 2 →서명

천식약 투약 양식

의료제공자 투약 지시 양식| 학교 보건 담당실 | 2022-2023 학년도 학교 간호사에게 제출하십시오. 6월 1일 이후 제출된 양식은 새 학년도 처리가 지연될 수 있습니다.

학부모/보호자는 읽고, 작성한 후 서명. 아래 서명함으로써, 저는 다음과 같은 내용에 동의합니다:

- 1. 저는 자녀의 의료 보건 담당자가 지시한 대로 학교에 자녀의 약을 보관하고 사용하는 것에 동의합니다. 저는 또한 학교에 자녀의 약에 필요한 장비를 학교에 보관 및 사용하는 것에 동의합니다.
- 2. 저는 다음 사항을 이해합니다:
 - 저는 학교 간호사에게 반드시 비-알부테롤 호흡기를 포함한 자녀의 약과 기구를 제공해야 합니다.
 - 학교에 제공하는 모든 처방 및 "일반 의약품"은 개봉하지 않은 새것으로 원래의 용기 그대로 가져가겠습니다. 학교에 자녀가 학교 일과 중 사용할 수 있도록 유효기간이 지나지 않은 최신 약을 제공하겠습니다.
 - O 처방약은 반드시 박스 또는 병에 **원래의** 약국 라벨이 붙어있어야 합니다. 라벨에는 다음 내용이 포함되어야 합니다: 1) 자녀의 이름, 2) 약국 이름 및 전화번호, 3) 자녀의 의사 이름, 4) 날짜, 5) 리필 숫자, 6) 약 이름, 7) 복용량 8) 약품 복용 시간, 9) 약품 투약 방법 10) 기타 지침.
 - 저는 자녀의 의료 보건 담당자와 의논하였으며 OSH가 자녀의 천식 처방약이 없을 때는 비축 약품을 투여하는 것에 동의하였음을 증명/확인합니다.
 - 저는 자녀의 약이나 의사의 지시가 변경되면 **즉시** 학교 간호사에게 반드시 알려야 합니다.
 - 저는 OSH 및 상기 의료 서비스를 자녀에게 제공하는데 관련된 소속 에이전트가 본 양식에 제공된 정보의 정확성에 의존함을 알고 있습니다.
 - 저는 본 투약 양식(MAF)에 서명함으로써 학교보건담당실(OSH)이 자녀에게 보건 서비스를 제공하도록 허가합니다. 이 서비스에는 OSH 의료 제공자 또는 간호사의 임상 평가 및 신체 검사가 포함되나 이에만 국한되지는 않습니다.
 - 이 MAF의 약품 처방은 서머 세션을 포함한 자녀의 학년 말 또는 학교 간호사에게 새로운 MAF를 제공할 때 (둘 중 이른 시점) 만료됩니다.
 - 이 약품 안내가 만료되면 저는 자녀의 학교 간호사에게 자녀의 의료 보건 제공자가 작성한 새로운 MAF를 제출하겠습니다. 새로 제출하지 않으면 제가 학교 간호사에게 OSH 의료 보건 제공자가 제 자녀를 검사하는 것을 원하지 않는다는 편지를 제공하지 않는 한 OSH 의료 보건 제공자가 제 자녀를 검사할 수 있습니다. OSH 의료 제공자는 자녀의 천식 증상 및 천식 약품에 대한 반응을 평가할 수 있습니다. OSH 의료 제공자는 약품 지시를 유지할지 혹은 변경할지 결정할 수 있습니다. OSH 의료 제공자는 새로운 MAF를 작성하여 자녀가 OSH를 통해 계속 보건 서비스를 받을 수 있도록 할 수 있습니다. 제 주치의 또는 OSH 의료제공자는 차후 천식 MAF 작성 시 제 서명이 필요 없습니다. 만약 OSH 의료 제공자가 제 자녀의 신규 MAF를 작성한다면 OSH 의료 제공자는 저와 자녀의 의료 담당자자에게 안내하려고 노력할 것입니다.
 - 이 양식은 양식에 설명된 천식 서비스에 대한 본인의 동의 및 요청을 대변합니다. 이것이 OSH가 요청한 서비스를 제공하겠다는 동의가 아닙니다. OSH가 이런 서비스를 제공하겠다고 결정하면 자녀는 학생 조정계획(Student Accommodation Plan)이 필요할 수 있습니다. 이 계획은 학교가 작성할 것입니다.
 - 자녀에게 케어 또는 치료를 제공할 목적으로 OSH는 자녀의 의료 상태, 약품 또는 치료에 대해 필요하다고 생각하는 정보를 얻을 수 있습니다. OSH는 자녀에게 의료 서비스를 제공하는 의료 보건 제공자, 간호사 또는 약사에게서 이 정보를 입수할 수 있습니다.

자가 투약(독립적인 학생만 해당):

• 저는 자녀가 스스로 약을 복용하도록 완전히 훈련되어 있고 복용할 수 있음을 보증/확인합니다. 또한 저는 자녀가 양식에 명시된 처방약을 학교에서 소지, 보관 및 자가 투여하는 것에 동의합니다. 상기 설명된 병 또는 박스에 이 약을 자녀에게 주는 것은 제 책임입니다. 자녀의 해당 약품 사용을 모니터하고 학교에서 제 자녀의 해당 약품 사용으로 인한 모든 결과는 또한 제 책임입니다. 제 자녀가 학교에서 약품을 소지 및 자가 투여할 능력이 있는지 학교 간호사가 확인할 것입니다. 또한 학교에 명확한 라벨이 부착된 박스 또는 병에 들어 있는 "여분"의 약품을 제공하는 것에 동의합니다.

알림: 비축 약품을 사용하기로 결정하셨다면, 귀하는 반드시 자녀의 천식 흡입기, 에피네프린 및 기타 승인된 자가 투약품을 학교 견학 및/또는 방과 후 프로그램에 적절하게 자녀가 사용할 수 있도록 자녀 편에 보내셔야 합니다. 비축 약품은 OSH 직원에 의해 학교 안에서만 사용할 수 있습니다.

학생 성:	이름:	Ml: 생년월일:					
학교 (ATS DBN/이름):		보로:	학군:				
학부모/보호자 성명(인쇄체):		학부모/보호자 이메일: _					
학부모/보호자 서명:		_ 서명한 날짜:					
학부모/보호자 주소:							
학부모/보호자 휴대 전화번호: _	기타	전화					
기타 비상시 연락할 수 있는 사람	기타 비상시 연락할 수 있는 사람 성명/관계:						
기타 비상시 연락 전화번호:							
For Office of	of School Health (OSH) Us	e Only / 학교 보건 담	당실(OSH) 전용				
OSIS Number:	Received by - Name: _		Date:				
☐ 504 ☐ IEP ☐ Other	Reviewed by - Name: _		Date:				
Referred to School 504 Coordinator:	☐ Yes ☐	No					

OSH Public Health Advisor (for supervised students only) ☐ OSH Asthma Case Manager (For supervised students only)

☐ Clarified

Confidential information should not be sent by email

Signature and Title (RN OR MD/DO/NP):

Services provided by: ☐ Nurse/NP

☐ Modified

☐ School Based Health Center

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