# MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH

**THIS FORM SHOULD BE USED FOR NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY**

Authorization for Administration of Medication to Students for School Year **2016–2017**

ATTACH STUDENT PHOTO HERE

| Student Last Name | First Name | Middle | Date of birth __/__/____ MM DD YYYY | ☐ Male ☐ Female |
|---|---|---|---|---|
| Guardian's e-mail address | | | OSIS Number ___ _____ | |
| School (include name, number, address and borough) | | | DOE District ___ | Grade / Class |

The following sections to be completed by Student's HEALTH CARE PRACTITIONER

**1. Diagnosis:** _____ ICD-10 Code ☐ ___.___

**Medication:** _____
Generic and/or Brand Name

Preparation/Concentration: _____

Dose: _____ Route: _____

**Select the most appropriate option for this student:**

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**
  - I attest student demonstrated the ability to self-administer the prescribe medication effectively for school/field trips/school-sponsored events. _____ practitioner's initials

** PARENT MUST INITIAL REVERSE SIDE

In School Instructions

☐ Standing daily dose: at __:__ AM / PM and __:__ AM / PM

AND/OR

☐ PRN

_____
*specify signs, symptoms, or situations*

☐ Time interval: q __ minutes or q __ 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: _____ Route: _____

**Select the most appropriate option for this student:**

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**
  - I attest student demonstrated the ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events. _____ practitioner's initials

** PARENT MUST INITIAL REVERSE SIDE

In School Instructions

☐ Standing daily dose: at __:__ AM / PM and __:__ AM / PM

AND/OR

☐ PRN

_____
*specify signs, symptoms, or situations*

☐ Time interval: q __ minutes or q __ 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: _____ Route: _____

**Select the most appropriate option for this student:**

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**
  - I attest student demonstrated the ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events. _____ practitioner's initials

** PARENT MUST INITIAL REVERSE SIDE

In School Instructions

☐ Standing daily dose: at __:__ am / pm and __:__ AM / PM

AND/OR

☐ PRN

_____
*specify signs, symptoms, or situations*

☐ Time interval: q __ minutes or q __ 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) | For Office of School Health (OSH) Use Only |
|---|---|
| | Revisions per OSH after consultation with prescribing health care practitioner. ☐ IEP |

| Health Care Practitioner (Please Print) LAST NAME | FIRST NAME | Signature |
|---|---|---|
| Address | Tel. No. (___)___-____ | Fax. No (___)___-____ |
| E-mail address* | Cell phone* (___)___-____ | |
| NYS License No (Required) __-_____ | Medicaid No _____ | NPI No. _____ Date __/__/____ |

**INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS**

*Confidential information should not be sent by e-mail

Rev

NYC Health

*NYC Department of Health and Mental Hygiene*
*Immunization Program*
*Vaccines For Children Program*

## ELIGIBILITY SCREENING FORM

**Provider Name:** Christine Uzoigwe,MD
9502 Foster Avenue
Brooklyn, NY 11236

**Date of Screening:** ___/___/___
MM DD YYYY

**HEALTH CARE PROVIDER:** A record must be kept in the healthcare provider's office that reflects the status of all children up to their 19th birthday who receive immunization through the NYC VFC program. The record may be completed by the parent, guardian, individual of record, or healthcare provider. The same record may be used for all subsequent visits as long as the child's health insurance status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

**PATIENT INFORMATION:**

**Child/Patient Date of Birth:** ___/___/___
MM DD YYYY

Child/Patient Last Name _____ First Name _____ MI _____

Parent/Guardian's Last Name _____ First Name _____ MI _____

**Check the appropriate eligibility category line below for children (up to their 19th birthday) who receive publicly purchased vaccine in New York.**

1. Medicaid/Medicaid managed care enrolled _____ Date
2. Uninsured (no insurance) _____ Date
3. Underinsured (insurance does not cover vaccines) _____ Date
4. Native American/Alaskan Native _____ Date
5. Not Eligible (insurance covers immunization) _____ Date
6. Child Health Plus B (CHPlus B) _____ Date

**EXPLANATIONS/INSTRUCTIONS FOR USE OF CATEGORIES ON BACK**

NEW PATIENT YES NO
ESTABLISHED PAT YES NO
If last was NEW visit billed ????

9502 Foster Ave Brooklyn NY 11236
Tel: 347-423-1845

Last Name First

Address City & State Zip

DATE OF BIRTH Gender: MALE FEMALE

Policy Holder Name Male Female

Relationship to Patient: Mom Dad Date of Birth

Insurance Name Insurance ID# SEND C

Email address: Reason for visit:

ASSIGNMENT: I ASSIGN AND REQUEST PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN SERVICES DESCRIBED BELOW.
RELEASE: I HERBY AUTHORIZE UNDERSIGNED PHYSICIAN TO INFORMATION TO MY INSURANCE CARRIER CONCERNING THE ILLNESS OR ACCIDENT.

SIGNED DATE
PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION, REGARDLESS OF INSURANCE OR OTHER THIRD PARTY

# FOR OFFICE USE

| FQHC Code | |
|---|---|
| FQHC Code: | 01 |
| FQHC Code: | 02 |
| FQHC Code: | 11 |
| FQHC Code: | 18 |
| FQHC Code: | 20 |

| PROCEDURES | |
|---|---|
| Spirometry | 94010 |
| ECG w/interpretation | 93000 |
| Cerumen Removal | 69210 |
| Colposcopy | 57452 |
| Colposcopy w/biopsy | 57455 |
| Allergy Test | 95024 |
| Nebulizer | 94640 |

| Vaccines | |
|---|---|
| Influenza | 90656 |
| TB Test Intradermal | 86580 |
| Tdap | 90715 |
| Pneumoccocal | 90732 |
| HPV | 90651 |
| Zoster | 90736 |

Injections:

| ULTRASOUND PROCEDURES | |
|---|---|
| Abdominal Ultrasound | 76700 |
| Renal / Retroperitoneal | 76770 |
| Abdominal Aorta | 93978 |
| Echocardiography | 93307 |
| 2D M Mode Doppler | 93320 |
| Color Doppler | 93325 |
| Venus Low. Extrem. | 93970 |

| PHYSICAL THERAPY | |
|---|---|
| Elec Stimulation | G0282 |
| EMS | 97032 |
| Hot/Cold Packs | 97010 |

| NEW OFFICE VISIT E&M | | FOLLOW UP VISIT E&M | | MEDICARE ONLY | |
|---|---|---|---|---|---|
| Office Visit 10 MIN | 99201 | Office Visit 5 MIN | 99211 | New Office Visit | G0466 |
| Office Visit 20 MIN | 99202 | Office Visit 10 MIN | 99212 | Established Office Visit | G0467 |
| Office Visit 30 MIN | 99203 | Office Visit 15 MIN | 99213 | Initial Preventive Physical Exam (IPPE) | G0468 |
| Office Visit 45 MIN | 99204 | Office Visit 25 MIN | 99214 | | |
| Office Visit 60 MIN | 99205 | Office Visit 40 MIN | 99215 | Annual Wellness (AWV) | |

| DIAGNOSIS | | | | | |
|---|---|---|---|---|---|
| Abdominal Pain | R10.9 | Dysuria | R30.0 | Neck Pain | M54.2 |
| Anemia | D64.9 | Fatigue | R53.83 | Obesity | E66.9 |
| Anxiety | F41.9 | Fatigue Chronic | R53.82 | Osteoarthritis | M19.9C |
| Arteriosclerosis | I70.0 | Fibroid Uterine | D25.9 | Pain in Limb | M79.609 |
| Asthma | J45.909 | Gastritis | K29.00 | Pancreatitis | K85.9C |
| BPH | N40.0 | Gerd | K21.9 | Pelvic Pain | R10.2 |
| Bronchitis Acute | J20.9 | Goitter | E04.9 | Peripheral Vasc Dis. | I73.89 |
| Bronchitis Chron | J42 | Gout | M10.9 | Peptic Ulcer | K27.9 |
| Bursitis | M71.50 | Headache | R51 | Pharyngitis | J02.9 |
| Cardiac Dysrhyth | I49.9 | Heart Murmur | R01.1 | Phlebitis | I80.9 |
| Cardiomegaly | I51.7 | Heartburn | R12 | PID | N73.9 |
| Carotid Stenosis | I65.29 | Hematuria | R31.9 | H. Pylori | B96.81 |
| Cellulitis | L03.90 | Hepatitis NOS | K75.9 | Pneumonia | J18.9 |
| Cerv radiculopathy | M54.12 | Hepatomegaly | R16.0 | Prostatitis | N41.9 |
| Chest Pain | R07.9 | Hiatal Hernia | K44.9 | Radiculopathy Uns | M54.1C |
| Chest Tightness | R07.89 | Hypercholestrolem | E78.00 | Rhinitis Allergic | J30.9 |
| Cholecystitis | K81.0 | Hyperlipidemia | E78.5 | Shoulder Pain | M25.51 |
| Cholelithiasis | K80.00 | Hypertension NOS | I10 | Sinusitis | J32.9C |
| Conjunctivitis Acu | H10.33 | HTN W/O Heart Fao; | I11.9 | Sprain of Back | S23.9XXA |
| Conjunctivitis Chr | H10.409 | Hyperthyroidism | E05.90 | Stress Incont F/M | N39.3 |
| Constipation | K59.00 | Hypothyroidism | E03.9 | Swelling Limb | M79.89 |
| COPD | J44.9 | Impacted Cerumen Bil. | H61.23 | Thyroid Disord | E07.9 |
| Cystitis Acute | N30.00 | Influenza | J10.1 | Tonsillitis Acut | J03.9C |
| Cystitis NOS | N30.90 | Incomnia UNSP | G47.00 | Tuberculosis | A15.0 |
| Depression | F32.9 | Irritable Colon | K58.9 | Urinary Incont | N39.42 |
| Dermatitis NOS | L25.9 | Ischemic Heart Dis. | I25.9 | UTI Urinary Trac | N39.0 |
| Diabetes T2 Con | E11.9 | Knee Pain | M25.569 | Bact. Vaginitis | N76.0 |
| Diabetes T2 Uncon | E11.65 | Lumbar Pain, Lumbag | M54.5 | Varicose Veins | I83.9C |
| Diabtic T2W Neuro | E11.40 | Menopausal Synd | N95.1 | Viral Synd | B97.89 |
| Diarrhea | R19.7 | Mitral Valve Insuf | I34.0 | Vitamin D Deficiency | E55.9 |
| Dizziness | R42 | Myocarditis NOS | I51.4 | Warts | B07.9 |

| LABORATORY | | | | | |
|---|---|---|---|---|---|
| Blood Glucose, mon. | 82962 | | | Hemoglogin | 85018 |
| Blood Glucose, vis. dips | 82948 | Pregnancy, urine | 81025 | Urine Dipstick | 81002 |
| Pulse Oximetry | 94760 | Blood Collection | 99000 | Pap Smear | 88150 |

# Christine A. Uzoigwe, MD FAAP

NEW PATIENT YES NO
ESTABLISHED PAT YES NO
If Est was NEW visit billed ????

9502 Foster Ave Brooklyn Ny 11236
TEL: 347-[illegible]-1245

DATE OF SERVICE

Last Name _____ First _____

Address _____ City & State _____ Zip _____

DATE OF BIRTH _____ Gender: MALE FEMALE

Policy Holder Name _____ Male ____ Female ____

Relationship to patient: Mom ____ Dad ____ Date of Birth _____

Insurance Name _____ Insurance ID# _____ SEND CAL

Email address: _____ Reason for visit: _____

ASSIGNMENT: I ASSIGN AND REQUEST PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN SERVICES DESCRIBED BELOW.
RELEASE: I HERBY AUTHORIZE UNDERSIGNED PHYSICIAN TO INFORMATION TO MY INSURANCE CARRIER CONCERNING THE ILLNESS OR ACCIDENT.

SIGNED _____ DATE _____
PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION, REGARDLESS OF INSURANCE OR OTHER THIRD PARTY INVOLVEMENT.

# FOR OFFICE USE

| NEW PATIENT | | | NEW | EST |
|---|---|---|---|---|
| Focused | 99202 | <1 YRS | 99381 | 99391 |
| Expanded | 99203 | 1-4 YRS | 99382 | 99392 |
| Comprehensive | 99204 | 5-11 YRS | 99383 | 99393 |
| Comprehensive (age 18+) | 99205 | 12-17YRS | 99384 | 99394 |
| | | 18-39YRS | 99385 | 99395 |
| ESTABLISHED PATIENT | | | | |
| Brief Exam | 99211 | | | |
| Limited Exam | 99212 | | | |
| Intermediate | 99213 | | | |
| Extended | 99214 | | | |
| Comprehensive | 99215 | | | |
| Counseling | 99402 | | | |

| COUNSELING | |
|---|---|
| Dietary Counseling | V65.3 |
| Exercise | V65.41 |
| Substance Use/Abuse | V65.42 |
| Injury Prevention | V65.43 |
| HIV Counseling | V65.44 |
| STD Counseling | V65.45 |
| Rocephin | J0696 |
| Nutritional Counseling | G0270 |
| Alcohol/Drug Counseling | G0396 |

| VACCINES | |
|---|---|
| DTAP | 90700 |
| FLU <3 90657 >3 90656 | |
| FluMist | 90660 |
| Gardasil | 90649 |
| HEP A | 90633 |
| HEP B 0-11YRS | 90744 |
| HIB | 90648 |
| IPV | 90713 |
| Meningococcal | 90734 |
| MMR | 90707 |
| Rotavirus | 90680 |
| PENTACEL | 90696 |
| PPD | 86580 |
| PREVNAR | 90670 |
| TDaP | 90715 |
| VARICELLA | 90716 |
| PEDIARIX | 90723 |
| Kinrix | 90696 |
| Proquad | 90710 |

| MISCELLANEOUS | |
|---|---|
| Urine Dipstick | 81000 |
| Lead Screen | 83655 |
| Blood Drawing < 3 | 36406 |
| Blood Drawing > 3 | 36410 |
| Assay Blood PKU | 84030 |
| Snellen Vision Exam | 92061 |
| Audiometry | 92551 |
| Umbilical Cauterization | 17250 |
| Office Emergency Care | 99058 |
| Admin.Vacc.>18 | 90471/90472 |
| Admin.Vacc.<18 | 90460/90461 |
| MINOR PROCEDURES | |
| Removal of Sutures | 15850 |
| Treat Elbow Dislocation | 24640 |
| Injection of Antibiotic | 96372 |
| Airway Inhalation Treat. | 94640 |
| Pulse Ox | 94760 |
| Albuterol Soln | J7611 |
| Glucose Dipstick | 82948 |

COMMENTS: _____

Date: _____

Doctor's Signature: _____

NYC Health

*NYC Department of Health and Mental Hygiene*
*Immunization Program*
*Vaccines For Children Program*

## ELIGIBILITY SCREENING FORM

**Provider Name:** _____ **Date of Screening:** ____/____/____
MM DD YYYY

**HEALTH CARE PROVIDER:** A record must be kept in the healthcare provider's office that reflects the status of all children up to their 19th birthday who receive immunization through the NYC VFC program. The record may be completed by the **parent, guardian, individual of record, or healthcare provider.** The same record may be used for all subsequent visits as long as the child's health insurance status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

**PATIENT INFORMATION:**

Child/Patient Date of Birth: ____/____/_____
MM DD YYYY

| Child/Patient Last Name | First Name | M.I |
|---|---|---|
| | | |

| Parent/Guardian's Last Name | First Name | M.I |
|---|---|---|
| | | |

**Check the appropriate eligibility category line below for children (up to their 19th birthday) who receive publicly purchased vaccine in New York.**

1. Medicaid/Medicaid managed care enrolled _____ Date
2. Uninsured (no insurance) _____ Date
3. Underinsured (insurance does not cover vaccines) _____ Date
4. Native American/Alaskan Native _____ Date
5. Not Eligible (insurance covers immunization) _____ Date
6. Child Health Plus B (CHPlus B) _____ Date

**EXPLANATIONS/INSTRUCTIONS FOR USE OF CATEGORIES ON BACK**

# DIVINE LOVE MEDICAL SERVICES, PC

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.**

I, _____, hereby acknowledge the, PC has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have a questions or complaints I may contact:

Privacy Contact # (347) 425-1849

I also understand that I am entitled to receive updates upon request if Divine Love Medical Services, PC amends or changes it Notice of Privacy Practices in a material way.

Patient Name _____

Patient/Guardian Signature _____

Relationship to Patient _____ Date _____

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**THIS SECTION IS TO BE COMPLETED BY DIVINE LOVE MEDICAL SERVICES, PC, IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMTN FROM PATIENT**

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- ☐ Notice of Privacy Practices Given – Patient Declined to sign
- ☐ Other (specify): _____

_____ _____

Name and Title of Employee Date

# DIVINE LOVE MEDICAL SERVICES, PC

## PEDIATRICS

### AUTHORIZATION FOR MEDICAL TREATMENT

I _____, (patient/patients parent or guardian) give authorization to the attending physician/physicians on staff at "Divine Love Medical Services, P.C.to evaluate and treat me/my son, daughter, or relative. (circle one) I understand that I will be informed of any medical treatment or procedures to properly treat me, or the patient.(circle one) Authorization is hereby granted for such treatments and procedures. My signature below will act as authorization for todays and all future medical treatment, unless I rescind such authorization in writing.

_____ _____

Patient or Parent/Guardian Signature Date

Who if anyone other than the responsible party has permission to be involved in your child's medical treatment including bringing them in for visits?

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____ _____

Patient or Parent/Guardian Signature Date

# DIVINE LOVE MEDICAL SERVICES, PC

## REGISTRATION FORM

### PATIENT INFORMATION

Date: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_) _____

Date of Birth: ____/____/____ Social Security: _____

Mother's Name: _____ D.O.B.: ____/____/____

Employer: _____ Work Phone: (_____) _____

Father's Name: _____ D.O.B.: ____/____/____

Employer: _____ Work Phone: (_____) _____

Whom may we than for referring you? _____

Person to contact in case of emergency: _____ Phone: (_____) _____

### INSURANCE INFORMATION

Name of Insured: _____ DOB: _____ Relationship to Patient: _____

Insurance Company: _____ Grp# _____ ID# _____

Ins. Co. Address: _____ INS Co. Phone: _____

**DO YOU HAVE ANY ADDITIONAL INSURANCE?** ☐ **Yes** ☐ **No** **IF YES, COMPLETE THE FOLLOWING**

Name of Insurance _____ Name of Insured: _____

Effective Date: _____ Relationship to Patient: _____

ID #: _____ Benefit Code: _____

***I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT:***

Signature: _____ Date: _____