DIVINE LOVE MEDICAL SERVICES, PC

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security 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 the 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* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). 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 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient 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 people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-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 provider listed below. 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 might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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

_____ Date: _____

Signature of patient or representative authorized by law.

* **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.**

DIVINE LOVE MEDICAL SERVICES, PC

Return to Work or School Certificate

_____ has been under my care
from_____ to _____ and is able to return to
school/work on _____Limitation /
Remarks_____
_____

Sig_____

Dr. Christine A. Uzoigwe, MD FAAP

9502 FOSTER AVE. BKLYN NY,11236

TEL. 347 425 1849

FAX.347 240 1505

DIVINE LOVE MEDICAL SERVICES, PC

Walk-In-Sign-In- Sheet

Date----------

	Name	YES/NO INSURANCE	ARRIVAL TIME
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			

Asthma Action Plan

[To be completed by Health Care Provider]

Medical Record #:	Updated On:

Name | Date of Birth

Address | Emergency Contact/Phone

Health Care Provider Name | Phone | Fax

Asthma Severity: ☑ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers: ☐Colds ☐Exercise ☐Animals ☐Dust ☐Smoke ☐Food ☐Weather ☐Other

If Feeling Well (Green Zone) — Take Every Day Long-Term Control Medicines

You have all of these:
- Breathing is good
- No cough or wheeze
- Can work / play
- Sleeps all night

Peak flow in this area: _____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

5-15 minutes before exercise use this medicine

If Not Feeling Well (Yellow Zone) — Take Every Day Medicines and Add these Quick-Relief Medicines

You have any of these:
- Cough
- Wheeze
- Tight chest
- Coughing at night

Peak flow in this area: _____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Call doctor if these medicines are used more than two days a week

Red Zone

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

Peak flow reading below: _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

SEEK EMERGENCY CARE or CALL 911 NOW if: Lips are bluish, Getting worse fast, Hard to breathe, Can't talk or cry because of hard breathing or has passed out

Make an appointment with your primary care provider within two days of an ER visit or hospitalization

Health Care Provider Signature | Date

Patient/Guardian Signature [I have read and understood these instructions] | Date

NYC Health
New York City Department of Health and Mental Hygiene
Michael R. Bloomberg, Mayor
Thomas.R Frieden, M.D., M.P.H., Commissioner
nyc.gov/health

New York City Asthma Initiative
Adapted from Finger Lakes Asthma Action Plan and NHLBI
Revised 06/04

WHITE - PATIENT COPY
YELLOW - SCHOOL/DAY CARE COPY
PINK - PROVIDER COPY

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex ☐ Female ☐ Male	Date of Birth (Month/Day/Year)
				___/___/___

Child's Address	Hispanic/Latino? ☐ Yes ☐ No	Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough	State	Zip Code	School/Center/Camp Name	District ___ Number ___	Phone Numbers Home / Cell / Work

Health Insurance (including Medicaid)? ☐ Yes ☐ No	☐ Parent/Guardian ☐ Foster Parent Last Name	First Name	Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis	☐ Seizure disorder
☐ Behavioral/mental health disorder	☐ Speech, hearing, or visual impairment
☐ Congenital or acquired heart disorder	☐ Tuberculosis *(latent infection or disease)*
☐ Developmental/learning problem	☐ Hospitalization
☐ Diabetes *(attach MAF)*	☐ Surgery
☐ Orthopedic injury/disability	☐ Other (specify) _____
Explain all checked items above.	☐ ***Addendum attached.***

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

_____

_____

PHYSICAL EXAM Date of Exam: ___/___/___

Height _____ cm (___ ___ %ile)

Weight _____ kg (___ ___ %ile)

BMI _____ kg/m² (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ cm (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

☐ Physical Exam WNL

	Nl	Abnl
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help

☐ Communication/Language ☐ Gross Motor/Fine Motor

☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
Child Care Only		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	Results
< 4 years: gross hearing	___/___/___	☐Nl ☐Abnl ☐Referred
OAE	___/___/___	☐Nl ☐Abnl ☐Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐Nl ☐Abnl ☐Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ Nl ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number _____ Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

												IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___	Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___	Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___	Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___	Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___	Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___	Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___	Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other _____	___/___/___	___/___/___	Polio 3	___/___/___

ASSESSMENT ☐ Well Child (Z00.129) ☐ Diagnoses/Problems *(list)* — ICD-10 Code

_____ _____

_____ _____

_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature	Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State

Facility Name	National Provider Identifier (NPI)

Address	City	State	Zip

Telephone	Fax	Email

DOHMH ONLY PRACTITIONER I.D.

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ I.D. NUMBER

REVIEWER:

FORM ID#

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

DIVINE LOVE MEDICAL SVCS,

FAX

TO: _____ **FAX:** _____

From: _____ **Date:** _____

Re: _____ **Page:** _____

_____

1.Urgent 2.for review 3. reply/comment 4.please Recycle

Please find enclosed the copies of the _____

T.347-425-1849 F.347-240-1505, 9502 Foster Ave. BKN,11236

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF NUTRITION

For WIC Use:

Date Mailed/ Given	Date Rec'd
Appt Date	WIC ID #

WIC MEDICAL REFERRAL FORM FOR INFANTS and CHILDREN

Child's Last Name (Print):_____ Child's First Name: _____

Parent/Caretaker's Name:_____ Street: _____ Apt:_____

City:_____ Zip:_____ On WIC Before: Yes ☐ No ☐ Sex: M ☐ F ☐

Phone: ( ) _____ - _____ Child's DOB: ____/____/____ Language(s) Spoken: _____

I authorize _____ (Health Care Provider) to release the information below to the WIC Program, and I authorize the WIC Program to release information about my infant/child to this health care provider for the purposes of coordinating his/her health care. If I need to transfer to another WIC Program, I authorize the release of this information to the transferring WIC Program. All information is considered confidential.

YOUR SIGNATURE: _____

Health Care Provider: Please complete this section.

BIRTH HISTORY: ☐ SGA (<10th Weight for Gestational Age)

Birth Weight _____lb _____oz *OR* _____kg

Birth Length _____in *OR* _____cm Weeks Gestation_____

WEIGHT and HEIGHT must be less than 60 days old on the date of the WIC appointment ____/____/____

Date Taken:

Current Weight ____lb ____oz *OR* ____kg ____/____/____

Current Height/Length ____in *OR* ____cm ____/____/____

Measurement Taken: ☐ Standing ☐ Recumbent (< 2 yrs)

HEMATOLOGY:

Date Taken:

Hgb _____gm/dL *OR* Hct _____% ____/____/____

Blood Lead _____mcg/dL at one year of age ____/____/____

Blood Lead _____mcg/dL at two years of age ____/____/____

Provide marker IMMUNIZATION dates or attach a copy of record.

	First	Second	Third	Fourth	Fifth
Hep B					
DTP/ DTap					
MMR					

SPECIFIC MEDICAL DIAGNOSIS OR NUTRITIONAL/HEALTH RISKS including ICD-9 code

Signature of Health Care Provider

Provider's Name (Please Print):

Title:

Medical Office/Clinic:

Street:

City: Zip:

Phone #: Fax #:

Date: ____/____/____

Send Completed Form To:

NEW YORK STATE DEPARTMENT OF HEALTH
WIC Program

WIC Medical Documentation

For WIC approved formula, nutritionals and supplemental foods

NEW YORK STATE | WIC Program

INSTRUCTIONS: Complete sections A-D for WIC participants requiring exempt formula, nutritionals and supplemental foods (NYS WIC Formulary: https://www.health.ny.gov/prevention/nutrition/wic/approved_formulas.htm). Incomplete forms will cause delays in issuance of prescribed products. The provision of formula/food is subject to WIC policies and procedures. Multiple formulas may be listed to allow for alternative options based on product availability. (Details on back)

A. Patient Information

Patient Name: _____ Date of Birth: / /

B. Formula

1. Formula/Nutritional Requested: _____
2. Product Form: ☐ Powder ☐ Concentrate ☐ Other: _____
3. Prescribed Amount: ☐ 20-32 oz/day (WIC Max) OR _____ oz/day (see back for additional details)
4. Length of Use: ☐ Until Age 1 OR _____ months (max of 12 for children/women)
5. Special Instructions/Comments: _____
6. WIC Qualifying Medical Condition (choose at least one):

☐ Developmental delay
☐ Dysphagia
☐ Failure to thrive
☐ Gastrointestinal diseases
☐ Immune system disorder
☐ Low birth weight (< 24 months only)
☐ Malabsorption syndromes
☐ Metabolic disorders
☐ Premature birth (< 24 months only)
☐ Severe food allergies
☐ *Other: _____

*Note: The following non-specific symptoms and conditions are not acceptable: dermatitis, formula/food intolerance, fussiness, gas, spitting up, constipation, diarrhea, vomiting, colic, underweight, overweight.

C. WIC Supplemental Food Restrictions, if applicable

Infants 6-11 months:

NOT allowed:
☐ Solids, provide formula only
☐ Infant Cereal
☐ Fruits/Vegetables

Children ≥ 12 months & Women:

NOT allowed:
☐ Solids, provide infant fruits and vegetables and infant cereal
☐ Solids, provide formula only
☐ Cheese/Milk/Yogurt ☐ Eggs ☐ Soymilk/Tofu
☐ Canned Fish ☐ Peanut Butter ☐ Other: _____

D. Prescribing Health Care Provider Information (MD, NP, PA)

Provider's Signature _____ Date / / Provider Stamp

Provider's Printed Name _____ Phone Number _____ Fax Number _____

Street Address _____ City, State, Zip Code _____

E. Participant Release of Information

I authorize the above health care provider and NYS WIC agency staff to disclose/discuss information regarding feeding needs. This permission is good for the length of this certification. I understand that I may cancel this permission at any time by request to my health care provider and WIC. This release is not a condition of WIC eligibility.

Participant/Parent/Caregiver Signature _____ Printed Name _____ Date / /

F. WIC Staff Use Only

WIC ID # _____ ☐ Consent on file at WIC Date Obtained: / / /

Date and Initial: _____ ☐ Approved ☐ Pending ☐ Disapproved

Comments: _____

Dr.Christine A. Uzoigwe, MD,FAAP

DIPLOMATE, AMERICAN BOARD OF PEDIATRICS.

9502 Foster Avenue,Brooklyn, NY 11236

Tel 3474251849,7186889620, fax 3472401505

Date----------

Name----------

Please see the checked items below

☐ The number we have on file is disconnected/ not in service/ wrong
Please give us your new phone number.

☐ We tried to reach you, but you were unavailable.

☐ The throat culture of your child was positive for Group A Beta Strep.
Please call the office for details.

☐ The latest blood test of your child showed Anemia. Please
Come for an iron prescription/ take vitamins with iron. See enclosed diet.

☐ The latest blood test of your child showed a low/ high WBC count. Please
come for repeat blood testing in _____ week/s

☐ The latest blood test of your child showed a high cholesterol
at _____ mg/dl. The normal is 170 mg/dl or lower. Please see enclosed diet.

☐ The latest blood test of your child showed a high triglyceride
at _____ mg/dl The normal is 129 mg/dl or lower. Please see enclosed diet

☐ The latest urine analysis of your child showed protein. Please come to
collect a specimen container to perform a 1st morning urine collection.

☐ The latest urine analysis done on your child showed bacteria. Please come
for a urine collection container.

☐ The latest blood/ urine/ stool test done on your child showed abnormal
results. Please call the office for details.

☐ Please call the office to speak to Dr. Bravo.

☐ Please call the office to schedule an appointment for a follow-up visit.

DIVINE LOVE MEDICAL SERVICES PC

9420 FOSTER AVENUE, BROOKLYN NY,11236 Tel 347 425-1849, Fax 347 240-1505

Receipt of Payment

Received From:_____ Date_____

Amount $_____ Payment Type CASH_____ Receipt #_____

Charge Details: DOS;_____

Date	Description	units	fees	payment	Total fees
	MEDICAL	1	$	$	$
	TOTAL				$

ACCOUNT BALANCE SUMMARY

TOTAL BALANCE$0

PATIENT BALANCE

INSURANCE BALANCE

Thank you for choosing Divine Love Medical

DIVINE LOVE MEDICAL SERVICES PC

9502 FOSTER AVENNUE BKLYN NY ,11236. TEL; 347-425 1849

MEDICAL CERTIFICATE/CLEARANCE

TO WHOM IT MAY CONCERN;

I, Christine Uzoigwe, MD FAAP, hereby certify that I am a physician licensed by the state of New York(License #243076) with office location at the above address.

I conducted a physical examination of---------- ---------- on the basis of this said examination, I conclude that s/he does not appear to have any physical or mental condition which would impair his/her ability to perform his/her duties and hence is medically cleared to work.

Sincerely,

Physician signature Physician name Date of exam.

DIVINE LOVE MEDICAL SERVICES PC

9420 FOSTER AVENUE, BROOKLYN NY,11236 Tel 347 425-1849, Fax 347 240-1505

Receipt of Payment

Received From:_____ Date_____

Amount $_____ Payment Type CASH_____ Receipt #_____

Charge Details: DOS;_____

Date	Description	units	fees	payment	Total fees
	MEDICAL	1	$	$	$
	TOTAL				$

ACCOUNT BALANCE SUMMARY

TOTAL BALANCE$0

PATIENT BALANCE

INSURANCE BALANCE

Thank you for choosing Divine Love Medical

DIVINE LOVE MEDICAL SERVICES, PC

Return to Work or School Certificate

_____ has been under my care from_____ to _____ and is able to return to school/work on _____Limitation / Remarks_____

_____

Sig_____

Dr. Christine A. Uzoigwe, MD FAAP

9502 FOSTER AVE. BKLYN NY,11236

TEL. 347 425 1849

FAX.347 240 1505

DLMS NEW PATIENT HISTORY

Patient Name:_____ Date Of Birth:_____

Birth History:

Adopted: Y / N
Multiple Birth: Y / N
Name of Hospital:_____
Term (in weeks):_____
Birth Weight: _____
Birth Length:_____
Condition at Birth (healthy?): Y / N
Please explain if No:_____
Delivery: C-Section / Vaginal
Breast Milk / Formula (type)_____

Assisted Conception: Y / N
Gestational Diabetes: Y / N
High Risk Pregnancy: Y / N
Induction of Labor: Y / N
Maternal Use of Alcohol: Y / N
Maternal Use of Tobacco: Y / N
Maternal Use of Drugs: Y / N
Surgeries (on baby): Y / N
Circumcision (Boys only): Y / N
Jaundice Y / N

Family History

Biological Mother:

Allergies:_____
Medications:_____
Health Concerns:_____
Drug/Alcohol Use:_____
Smoker: Y / N

Biological Father:

Allergies:_____
Medications:_____
Health Concerns:_____
Drug/Alcohol Use:_____
Smoker: Y / N

Sibling:

Allergies:_____
Developmental Delays:_____
Asthma: Y / N
Anemia: Y / N
Other:_____

Sibling:

Allergies:_____
Developmental Delays:_____
Asthma: Y / N
Anemia: Y / N
Other:_____

Extended Family History

Please list any family members with these health concerns

Kidney/Liver Disease:_____
Stroke:_____
Cancer:_____
Asthma:_____
Allergies:_____
Sudden Death:_____
Developmental Disability:_____
Seizures:_____

High Cholesterol:_____
High Blood Pressure:_____
Heart Problems:_____
Diabetes:_____
Hypo/Hyper Thyroid:_____
Mental Illness:_____
Reflux:_____
Anemia:_____

Social History

Who lives in home:_____
Smokers in home: Y / N

Pets in Home:_____

AT-16

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
Albany, New York 12234

PHYSICAL FITNESS CERTIFICATION

(Name of Applicant) (Address)

(Date of Birth) ☐Male ☐Female ☐Other

INSTRUCTIONS TO HEALTHCARE PROVIDER:
Complete Part A unless certificate is limited –in which case complete Part B

A. I hereby certify that I have examined the above-named applicant and find they are physically qualified for lawful employment.

(Date of Physical) (Signature of Healthcare Provider)

(Address of Healthcare Provider)

B. I hereby certify that I have examined the above-named applicant and find they have a disability that requires limited employment.

(1) Disability —

(2) Occupation —

(3) Employer —

(Date) (Signature of Healthcare Provider)

(Address of Healthcare Provider)

If a limited certificate is indicated, the disability, occupation, and employer must be indicated to make this certificate valid.

Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2023–2024**

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: _____ Weight: ___

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

DOE District: ___ Grade: _____ Class: _____

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

History of anaphylaxis? ☐ Yes Date: _____ ☐ No

If yes, system affected ☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic

Treatment: _____ Date: _____

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 REACTION

A. Immediately administer epinephrine ordered below, then call 911.

☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg

Give intramuscularly in the anterolateral thigh for any of the following signs/symptoms (retractable devices preferred) :

- 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 REACTION (parent must supply medicine for use in medical room)

For any of the following signs and symptoms _____, give:

- Benadryl _____ mg po Q6 hours prn
- Name: _____ Preparation/Concentration:_____ Dose:_____ PO ☐ Q4 hours ☐ Q6 hours ☐ Q12 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 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): _____ Signature: _____

NYS License # (Required): _____ NPI #: _____ **Please check one:** ☐ MD ☐ DO ☐ NP ☐ PA Date: _____

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 3/23 **PARENTS MUST SIGN PAGE 2 →**

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

Attach student photo here

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2023-2024

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: _____ DOE District: ____ Grade/Class: _____

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

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

☐ Albuterol [Only generic Albuterol MDI w/ individual spacer is provided by school; this will be used if prescribed medication below is unavailable)
Standard Order: Give 2 puffs q 4 hrs PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath.
Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE.

Other Quick Relief Medication:
- ☐ Other Albuterol Dosing: Name:_____ Strength : _____ Dose:____ puffs every ____ hours. *If not symptom-free within 20 mins may repeat ONCE*
- ☐ Airsupra (albuterol & budesonide) Strength_____Dose____puffs PRN every ___hrs. *If not symptom-free within 20 mins may repeat ONCE*
- ☐ Symbicort (formoterol & budesonide) Strength : _____ Dose:_____ puffs every _____min or ____hrs. ☐ *May repeat ONCE PRN*
- ☐ Albuterol with ICS : ☐ Albuterol ___puffs followed by Flovent _____ puffs every _____hrs. *If not symptom-free in 20 mins may repeat ONCE*
  ☐ Albuterol ___puffs followed by Qvar_____ puffs every ___hrs. *If not symptom-free in 20 mins may repeat ONCE*
- ☐ Albuterol MDI _____puffs followed by ICS (Name) _____ Strength: _____puffs every____ hrs

☐ URI Symptoms/Recent Asthma Flare: 2 puffs @noon for 5 school days when directed by PCP
Name:_____ Dose: _____ puffs/ _____ AMP q _____ hrs.

☐ **Pre-exercise:** Name:_____ Dose: _____ puffs/ _____ AMP 15-20 mins before exercise.

Special Instructions:_____

Controller Medications for In-School Administration (Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ Fluticasone [Only Flovent® 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

☐ Symbicort (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

NYS License # _____ NPI # : _____ Signature: _____ Date: _____

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 →