

New York City Citywide Immunization Registry (CIR)



Online Registry – Asthma Medication Administration Form (Asthma MAF) Guide

NYC Department of Health & Mental Hygiene
BEHS, OSH and BOI Collaboration
July 2026

Office of School Health – Asthma MAF

ASTHMA MEDICATION ADMINISTRATION FORM ASTHMA PROVIDER MEDICATION ORDER Office of School Health School Year 2026-2027 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 pharmacy name and phone number, 8) when to take the medicine, 9) how to take it. - I certify/confirm that I have checked with my child stock medication in the event my child's as - I must immediately tell the school nurse/SBHC - OSH and its agents involved in providing the ab - By signing this medication administration form (f my child. These services may include but are no nurse. - The medication order in this MAF expires at the school nurse/SBHC provider a new MAF (which - When this medication order expires, I will gi practitioner. If this is not done, an OSH hea SBHC stating that I do not want my child to b assess my child's asthma symptoms and respo medication orders will remain the same or nee continue to receive health services through th need my signature to write future asthma MAFs. practitioner will attempt to inform me and my chi - This form represents my consent and request fo agreement by OSH to provide the requested se Accommodation Plan. This plan will be complete - For the purposes of providing care or treatment medical condition, medication or treatment. OS has given my child health services. NOTE: If you opt to use stock medication, y medications with your child for a school trip OSH staff. FOR SELF ADMINSTRATION - I certify/confirm that my child has been fully trained him or herself the medicine prescribed on this for boxes as described above. I am also responsible for school. The school nurse/SBHC will confirm my ch "back up" medicine in a clearly labeled box or bottle.	Attach student photo here ASTHMA MEDICATION ADMINISTRATION FORM PROVIDER MEDICATION ORDER FORM Office of School Health School Year 2026-2027 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 DSN/Name, address, and borough): _____ HEALTH CARE PRACTITIONERS COMPLETE BELOW Diagnosis (see NAEPF Guidelines) ☐ Other: _____ Severity (see NAEPF Guidelines) ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Unknown Control (see NAEPF Guidelines) ☐ Well Controlled ☐ Not Controlled / Poorly Controlled ☐ Unknown Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown) ☐ Y ☐ N ☐ U History of life-threatening asthma (loss of consciousness, hypoxic seizure, or intubation) ☐ Y ☐ N ☐ U History of asthma-related PICU admissions (ever) ☐ Y ☐ N ☐ U Received oral steroids within past 12 months times last: _____ ☐ Y ☐ N ☐ U History of asthma-related ER visits within past 12 months times last: _____ ☐ Y ☐ N ☐ U History of asthma-related hospitalizations within past 12 months times last: _____ ☐ Y ☐ N ☐ U History of food allergy or eczema, specify: _____ ☐ Y ☐ N ☐ U Excessive Short Acting Beta Agonist (SABA) use (daily or > 2 times a week)? Home Medications (include over the counter) ☐ Reliever: ☐ Albuterol ☐ Budesonide/formoterol ☐ Other _____ ☐ Controller: ☐ Albuterol ☐ Budesonide/formoterol ☐ Other _____ ☐ 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 - Emergency Plan: In Respiratory Distress: call 911 and give albuterol 6 puffs; may repeat Q 20 minutes until EMS arrives! - Individual spacers are provided by the school. Schools will only provide Albuterol MDI and Fluticasone 110 ucg - Standard Albuterol Order: 2 puffs Q4 hours 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: ☐ Albuterol _____ Dose: _____ puffs/AMP q _____ hrs prn symptoms for _____ days or as per PCP's Special Instructions/Other Orders below ☐ URI Symptoms/Recent Asthma Flare: ☐ Albuterol _____ Dose: _____ puffs/AMP q _____ hrs prn symptoms for _____ days or as per PCP's Special Instructions/Other Orders below Other Anti-inflammatory Reliever 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 mcg _____ puffs every 4 hours PRN respiratory symptoms. ☐ Albuterol _____ puffs + ICS (provided by parent) Name: _____ Strength: _____ Dose: _____ puffs every 4 hours PRN respiratory symptoms. ☐ Albuterol or Other Quick-Relief Medication: Name: _____ Strength: _____ Dose: _____ puffs/AMP: _____ every _____ hours PRN respiratory symptoms Special Instructions/Other Orders Controller Medications for In-School Administration (Recommended for Persistent Asthma, per NAEPF 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 ☐ QB two time(s) a day Time: _____ AM and _____ PM ☐ Budesonide/formoterol (provided by parent). Standing Daily Dose: _____ puff(s) ☐ one ☐ QB 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: _____

The **Asthma Medication Administration Form (Asthma MAF)** is a provider medication order for the Office of School Health.

- The form is usually submitted in paper format (left image)
- This form critical to ensure students receive school nurse assisted asthma care.
- **Absence of an MAF will delay care and use of emergency services.**

Asthma MAF: Online Registry Pre-completed Form



To fill out the electronic asthma MAF:

- Go to Reports, then click the **Pre-completed Forms and Referrals** tab
- Scroll to bottom of page to **Pre-Completed Forms**

- **NEW** If applicable for this patient, view latest available risk assessment and home inspection results here, or make a referral below.
- Use this page to generate forms that are pre-completed with information from the Registry. Only the Child & Adolescent Health Examination Form can be saved to the Registry and re-used by users with read/write status. The "Healthy Homes Program - Individuals with Asthma living with Pests and/or Mold Referral Form" is available to users with read/write and read-only status.
- ➡ Unless otherwise noted, the pre-completed forms and referral forms on this page are provided in Adobe Acrobat PDF format. You may edit fillable fields on the form, and then print the forms to give to the parent or guardian of the child. NOTE: For best results, you may need to download or update your current version of Adobe Reader (we recommend version 10.0 or greater), which can be found [here](#).

Available Referral Forms

As of October 14, 2025, the Early Intervention Referral form is being replaced by the NYC Early Intervention Portal which (opens in a new window). When the online referral is completed at the child's healthcare visit, the parent can provide consent. You can also directly refer their child for early intervention using the NYC EI Referral Portal, or they can call 311 and ask for "Early Intervention Program" and to make a referral, click [here](#) (opens in new window).

 [WIC Medical Referral Form for Infants and Children \(6/22\)](#) (opens in new window) This is an outside link to the NYS WIC form. Currently, this form will not be prepopulated. Please print the immunization record separately and attach to the form.

For additional information please refer to our [CIR Full Guide](#)

 **NEW** [Healthy Homes Program - Individuals with Asthma living with Pests and/or Mold Referral Form](#) NYC DOHMH's Healthy Homes Program is offering free home inspections to identify and address pest or mold-related asthma triggers in addition to conditions conducive to pests or mold, such as water leaks and holes. This service is limited to patients diagnosed with moderate or severe persistent asthma living within the 5 boroughs of New York City. For more information about this service, please click [here](#). For a Patient Education Sheet, click [here](#).

Other forms available:

- **Child & Adolescent Health Examination (CH205) form**
- **Healthy Homes Program** See the referral resource [sheet](#)
- **WIC Medical Referral form** can be printed; pre-prepopulated form not available at this time

Asthma MAF: Create New Form

Pre-Completed Forms

Create Forms Using the new Asthma Medication Administration Form (MAF). [View the Online MAF Guide.](#)

If a form is in status IN_PROGRESS, you must resume it, or delete it.

If a form is in status AWAITING_SIGNATURES, you must wait for parent's signature, or delete it.

Once all forms are in status SIGNED, you may create a new one.

Please remind parents/guardians to go to My Vaccine Record to view/download/print their completed MAF and immunization record.

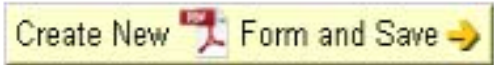
NEW  The button is a yellow rectangle with a red border. It contains the text "Create New" in black, a small red icon of a document with a plus sign, the text "Form and Save" in black, and a yellow arrow pointing right.

No Asthma Medication Administration Forms to display. You may create one using the "Create New" button.

Create Forms Using the Child & Adolescent Health Examination Form (CH205 form) for School, Camp/After School Programs, Early Intervention (Medical form) and Child Care programs. [View the Online CH205 Form Guide.](#)

- Use Registry data (Patient Information, Immunizations, and Lead Tests) to create Child & Adolescent Health Examination Forms (CH205 form). The immunizations displayed include only events which are considered valid according to the New York City Childhood Immunization Schedule.

To fill out the electronic asthma MAF:

- Go to Reports, then click the **Pre-completed Forms and Referrals tab**
- Scroll to middle of page to **Pre-Completed Forms**
- Select  to begin filling out the asthma MAF.

Asthma MAF: Verify Patient Information

Verify Patient Information

- This is an opportunity to update or correct patient demographic information in the CIR. Any additional information you update will become part of the patient's record.
- The following demographic information from this screen will automatically appear on the School Form: First Name, Middle Name, Last Name, Date of Birth, Sex, Race, and Ethnicity.
- If your patient was previously an inactive patient, creating a CH205 form will automatically activate the patient record.

Patient Information			
First Name	JANE	Alternate First [†]	
Middle Name	T		
Last Name	TEST	Alternate Last [†]	
DOB	01 01 2020		
	mm/dd/yyyy		
Sex	Female		
Race	AMERICAN INDIAN OR ALASKA NATIVE		
Ethnicity	Hispanic or Latino		
House No. / Street / Apt. No.	1234	EAST	10
City / State / ZIP	NEW YORK	NY	11101
Medical Rec. No.		Medicaid No. (AA#####) [†]	
Mom DOB [†]			
	mm/dd/yyyy		
Mom First Name [†]		Mom Maiden Name [†]	
Primary Contact	First Name JANE	Last Name	Relationship Mother
Home Phone	(123) 456-7890	☒ Cell/Mobile & Home Phone are the same Selecting checkbox will copy the Cell/Mobile Phone number and the Home Phone number to both fields.	
NEW Cell/Mobile	(123) 456-7890		
NEW Email	test.test@health.ny.gov		
Note: To request to remove a mobile phone number, please send a request to cir-records@health.nyc.gov and include only the CIR ID and phone number to remove, or call 347-396-2400.			

Verify the patient and family's information:

- This page will **pre-populate** with information saved within CIR.
- If the patient was born outside of New York City, enter all information in the **Mother** section
- Complete the **Primary Contact** section
- This is an opportunity to update any **contact information**.

Confirm or update the cell phone and/or email address for **MAF electronic signature**
Cell phone and email address is needed for parent access to the form later.

Asthma MAF: Verify Immunization Data

Verify Immunization Data

To ensure not to miss an opportunity to vaccinate, please review the immunization record for vaccines due. Use [Add/Edit](#) above to report additional or edit existing immunizations, or click Continue.

Immunization History						
Event	1	2	3	4	5	Next Due
Influenza 0 Event/s						Due now Influenza
HepB 0 Event/s						Due now HepB
Rotavirus 0 Event/s						Not recommended after 8 months.
DTP 0 Event/s						Due now DTaP
Hib 0 Event/s						Not generally recommended after 5 years
Pneumococcal 0 Event/s						Not Recommended
Polio 0 Event/s						Due now Polio
MMR 0 Event/s						Due now MMR
Varicella 0 Event/s						Due now Varicella
Zoster 0 Event/s						Due on 01/01/2070 Zoster (shingles, Shingrix)
HepA 0 Event/s						Due now HepA
Meningococcal (MenACWY) 0 Event/s						Recommended for high risk groups >= 2 months old, otherwise Due on 01/01/2031 MenACWY
Human Papillomavirus 0 Event/s						Due on 01/01/2029 Human Papillomavirus
H1N1 Influenza 0 Event/s						No longer recommended
Meningococcal B 0 Event/s						Not recommended
COVID-19 0 Event/s						Due now COVID-19, mRNA
Orthopoxvirus 0 Event/s						
RSV 0 Event/s						Recommended for high risk groups >= 50 years old, otherwise Due on 01/01/2095 RSV, Vaccine/mAb,
Other Vaccines						
Other 0 Event/s						

Verify any updates to the **patients’ immunization data.**

This page will also prompt you for any vaccines that are due.

Asthma MAF: Verify Lead Data

Verify Lead Data

If there are lead blood tests missing from the table below or you would like to report additional lead blood tests, you can report them to the Lead Poisoning Prevention Program by clicking [here](#).

Lead Test History				
More useful lead information is available in the Tools section.				
Event	Date	Test Type	BLL	Recommendation
	There are no lead tests reported for this patient.			

Previous

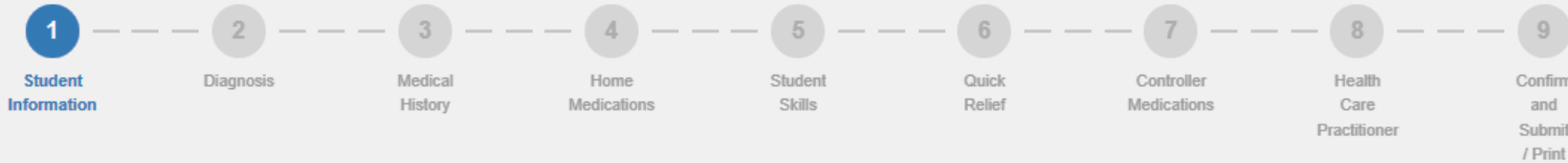
Next

Verify any updates to the **patients’ lead blood tests**.

You may also report them to the Lead Poisoning Prevention Program through this page.

Asthma MAF: Student, Parent/Guardian – Step 1

VERIFY STUDENT, PARENT/GUARDIAN, AND EMERGENCY CONTACT INFORMATION



STUDENT INFORMATION

First name* Middle initial Last name* Date of Birth* Sex ☐ Male ☒ Female

Borough* School (DBN / Name)* District*

Can't find your school's address? Select "Other" to enter it manually.

OSIS Number / Student ID Grade* Class

Parent / Guardian Information

First name* Last name* Email*

Address* City* State* Zip*

Cell Phone* Other Phone

Emergency Contact

First name* Last name* Relationship* Phone*

Next

In the form, first verify the patient/student information:

- Any information saved in CIR will **pre-populate** into the appropriate fields.
- Choose the Borough of the school. You can begin typing and search for School (DBN/Name) field.
- If a school is part of the list, the School District will auto-fill.
- If the student is in a public school, they will be **required** to enter an OSIS number/student ID.

All fields marked with an asterisk (*) are required to move forward.

Asthma MAF: Asthma Diagnosis – Step 2

DIAGNOSIS, CONTROL, AND SEVERITY ASSESSMENT

✓

2

3

4

5

6

7

8

9

Student Information

Diagnosis

Medical History

Home Medications

Student Skills

Quick Relief

Controller Medications

Health Care Practitioner

Confirm and Submit / Print

ASTHMA DIAGNOSIS (Select all that apply)

Diagnosis * ☒ Asthma ☐ Other: Specify	Severity * (see NAEPP Guidelines) ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Unknown	Control * (see NAEPP Guidelines) ☐ Well Controlled ☐ Not Controlled / Poorly Controlled ☐ Unknown
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Previous

Next

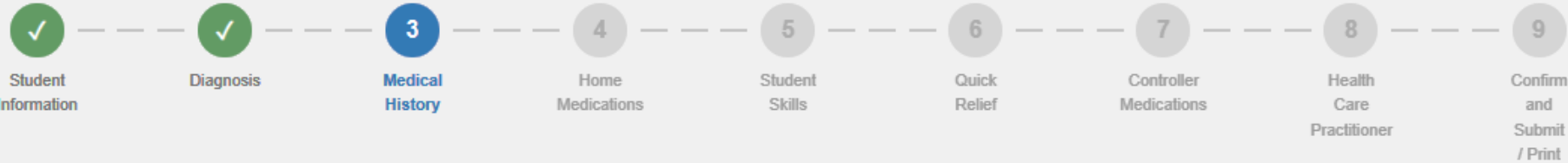
Next is to provide the student's diagnosis.

- If the student has an **asthma diagnosis**, this will require severity and control to be filled in.
- Any other diagnosis must be further specified in the text box.

All fields marked with an asterisk (*) are required to move forward.

Asthma MAF: Medical History - Step 3

PATIENT ASTHMA MEDICAL HISTORY



Student Asthma Risk Assessment Questionnaire (required; select one for each question below)

History of life-threatening asthma (loss of consciousness, hypoxic seizure, or intubation) *

☐ Yes ☐ No ☐ Unknown

History of asthma-related PICU admissions (ever) *

☐ Yes ☐ No ☐ Unknown

Received oral steroids within past 12 months *

☐ Yes ☐ No ☐ Unknown

History of asthma-related ER visits within past 12 months *

☐ Yes ☐ No ☐ Unknown

History of asthma-related hospitalizations within past 12 months *

☐ Yes ☐ No ☐ Unknown

History of food allergy or eczema, specify: *

☐ Yes ☐ No ☐ Unknown

Excessive Short Acting Beta Agonist (SABA) use (daily or > 2 times a week)? *

☐ Yes ☐ No ☐ Unknown

Number of times Last time mm/dd/yyyy ⓘ

Number of times Last time mm/dd/yyyy ⓘ

Number of times Last time mm/dd/yyyy ⓘ

Specify food allergy or eczema

Previous

Next

Next is to provide the student's medical history, by completing the **Student Asthma Risk Assessment Questionnaire**.

- Statements with additional information needed will become **required** if “**Yes**” is selected.

All fields marked with an asterisk (*) are required to move forward.

Asthma MAF: Home Medications - Step 4

HOME MEDICATIONS INCLUDING OVER THE COUNTER

✓

Student Information

✓

Diagnosis

✓

Medical History

4

Home Medications

5

Student Skills

6

Quick Relief

7

Controller Medications

8

Health Care Practitioner

9

Confirm and Submit / Print

HOME MEDICATION INCLUDING OVER THE COUNTER (Select all that apply)

☐ None

☐ Reliever

☐ Albuterol

Dosage

Frequency

☐ Budesonide/formoterol

Dosage

Frequency

☐ Other

Medication name

Dosage

Frequency

☒ Controller

☒ Albuterol

Dosage*

Frequency*

☒ Budesonide/formoterol

Dosage*

Frequency*

☒ Other

Medication name*

Dosage*

Frequency*

☐ Other

Medication name

Dosage

Frequency

Previous

Next

Under **Home Medications**, enter all the medications a patient is taking for their asthma at home.

- Any medications must have their dosage and frequency listed out.

Asthma MAF: Student Skills – Step 5

STUDENT SKILL LEVEL FOR MEDICATION ADMINISTRATION

✓
Student Information

✓
Diagnosis

✓
Medical History

✓
Home Medications

5
Student Skills

6
Quick Relief

7
Controller Medications

8
Health Care Practitioner

9
Confirm and Submit / Print

STUDENT SKILL LEVEL (select the most appropriate option)

☐ Nurse-Dependent Student: nurse must administer medication

☐ Supervised Student: student self-administers, under adult supervision

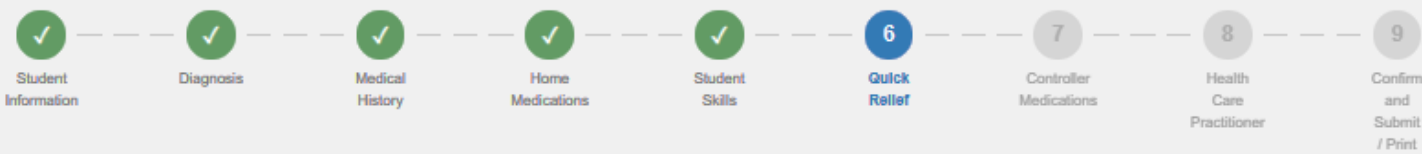
☐ Independent Student: student is self-carry/self-administer

☐ I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school-sponsored events. Practitioner's Initials:

Previous

Next

The **Student Skill Level** section is for providers to attest how much support students need when administering their medication.



Quick Relief In-School Medication

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

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

Standard Albuterol Order: Albuterol: Give 2 puffs Q4 pm 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

☐ Albuterol Dose: puffs / AMP ☐ 15-20 min before exercise ☐ PRN

☐ Budesonide/formoterol Dose: puffs / AMP ☐ 15-20 min before exercise ☐ PRN

☐ URI Symptoms/Recent Asthma Flare

☐ Albuterol Dose: puffs / AMP q hrs PRN symptoms for days

☐ Budesonide/formoterol Dose: puffs / AMP q hrs PRN symptoms for days

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 puffs every 4 hours PRN respiratory symptoms.

☐ Albuterol puffs + ICS (provided by parent) Name:

Strength Dose: puffs every 4 hours PRN respiratory symptoms.

☐ Albuterol or Other Quick-Relief Medication Name:

Strength Dose: puffs / AMP every hours PRN respiratory symptoms

Special Instructions/Other Orders:

Previous

Next

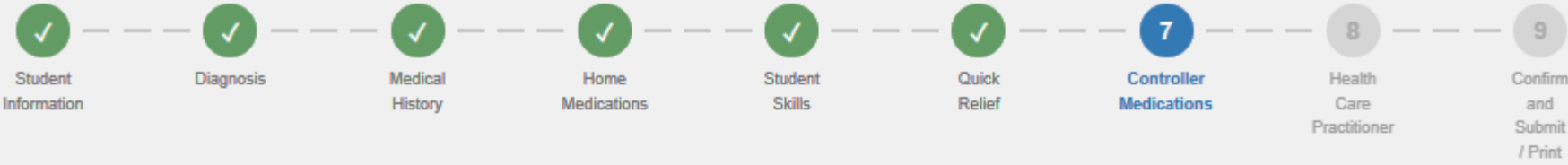
Asthma MAF:

Quick Relief - Step 6

This section refers to all **Quick Relief In-School Medication** that should be administered.

As you select certain medications, it will prompt you to fill out the required fields in each section.

CONTROLLER MEDICATIONS FOR IN-SCHOOL ADMINISTRATION



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: hh:mm aa and hh:mm aa

☐ Budesonide/formoterol (provided by parent).

Standing Daily Dose: puff(s) ☐ one OR ☐ two time(s) a day Time: hh:mm aa and hh:mm aa

Special Instructions:

☐ Other ICS (provided by parent)

Standing Daily Dose: Name:

Strength: Dose: Route:

Frequency: ☐ one OR ☐ two time(s) a day Time: hh:mm aa and hh:mm aa

[Previous](#)

[Next](#)

Asthma MAF: Controller Medication-Step 7

Similar to the Quick Relief page, all **Controller Medications** needed for in-school administration should be selected.

You will be prompted to fill out how much & how often the dose should be administered.

Click on the clock or type in the times, including AM/PM, that the dose should be administered.

Asthma MAF – Health Care Practitioner Signature – Step 8

HEALTH CARE PRACTITIONER INFORMATION AND SIGNATURE

✓

✓

✓

✓

✓

✓

✓

8

9

Student Information

Diagnosis

Medical History

Home Medications

Student Skills

Quick Relief

Controller Medications

Health Care Practitioner

Confirm and Submit / Print

HEALTH CARE PRACTITIONER

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.

First name *

Last name *

☒ MD ☐ DO ☐ NP ☐ PA

NYS License # *

NPI # *

TEST

000000

066075

Completed by Emergency Department Medical Practitioner: (ED Medical Practitioners will not be contacted by OSH/SBHC Staff) ☐ Yes ☐ No

Address *

City *

State *

Zip Code *

42-09 28 ST 5TH FLOOR

QUEENS

NY

11101

Telephone *

Cell Phone

Fax

Email *

Signature

Date *

06/29/2026

Clear

Previous

Next

On the **Health Care Practitioner Signature** page, confirm your provider details.

- The NYS License, NPI and address details are all prefilled from your CIR account.
- Once verified, add your signature using your mouse.

Asthma MAF: Confirm and Submit – Step 9

REVIEW AND CONFIRM YOUR ASTHMA MEDICAL ACTION FORM

✓

Student Information

✓

Diagnosis

✓

Medical History

✓

Home Medications

✓

Student Skills

✓

Quick Relief

✓

Controller Medications

✓

Health Care Practitioner

9

Confirm and Submit / Print

Review Your Asthma Medical Action Form

You have completed all the required steps for creating an Asthma Medical Action Form for patient **XAVIER T. TEST**.

Please review the information you have entered. If you need to make changes, click the **Previous** button to return to the previous step.

When you are satisfied with the information, click **Submit** to save the form and generate a PDF, or click **Print** to print the form.

1. Student Information

Name:

XAVIER T. TEST

Date of Birth:

09/08/2020

Sex:

Male

OSIS Number:

000000000

Grade:

Post-ED

School Information

School:

X754@12XB54 - P754X@HB54X, 921 East 228th Street, X

After submitting the form, the practitioner informs the parent/guardian that they will receive an email and text message with a link to an **Online Parent Signature** form.

16

Asthma MAF: Consent to Order email and text message Request for Signature

Reminder - Request for Signature - Asthma Medication Administration Form

noreply-osh@health.nyc.gov

To: Joohee Suh

Retention: DOHMHRetentionPolicy (8 years) Expires: Fri 6/9/2034 10:07 AM

Thu 6/11/2026 10:07 AM

Dear GOLDILOCKS Suh,

Do not reply, as this mailbox is not monitored.

Please read through the consent for the Asthma Medication Administration Form and click the link below to electronically sign the consent.

For any questions about the Asthma Medication Administration Form, please reach out to your provider.

For any general questions about medication administration forms, please reach out to your school nurse.

For the consent in 13 additional languages, please see the link: [Asthma MAF \(Additional Languages\)](#).

ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year 2026–2027

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 prescriptions 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.

Please click this link to consent: <https://immunize.nyc/uat/online-registry/asthma-maf/6a0f0ddd6b5ecc2ae25c36ac/signature/>

Thank you,

NYC Office of School Health

The parent listed on the form receives a **Consent to Order** by email. The link allows the parent to review the contents of the order and to sign the **Online Parent Signature form**.

The link is also sent to the cell phone listed on the form. The Health Department uses 85080 short code to send text messages.

← 85080

Use this Asthma MAF link to consent:

<https://immunize.nyc/uat/online-registry/asthma-maf/6a4183e9b21c6c4f4544c709/signature/>

6:27 PM

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Asthma MAF: Online Parent Signature form

1

ASTHMA MEDICATION ADMINISTRATION FORM - VERIFY IDENTITY

To access the form for signature, please enter the student's date of birth.

Student Date of Birth

mm/dd/yyyy



VERIFY & LOAD FORM

2

ASTHMA MEDICATION ADMINISTRATION FORM — PATIENT REVIEW & SIGNATURE

Please review the information below and sign at the bottom to authorize this Asthma Medication Administration Form.

Student Information

First Name

Last Name

Parent / Guardian Signature

By signing below, I authorize this Asthma Medication Administration Form and confirm that the information above is accurate.

3

CLEAR

4

SUBMIT SIGNATURE

1. Verify Identity by entering the date of birth
2. Review the form
3. Add Signature
4. Submit

A copy of the form will be sent to the school district by email from noreply-osh@health.nyc.gov

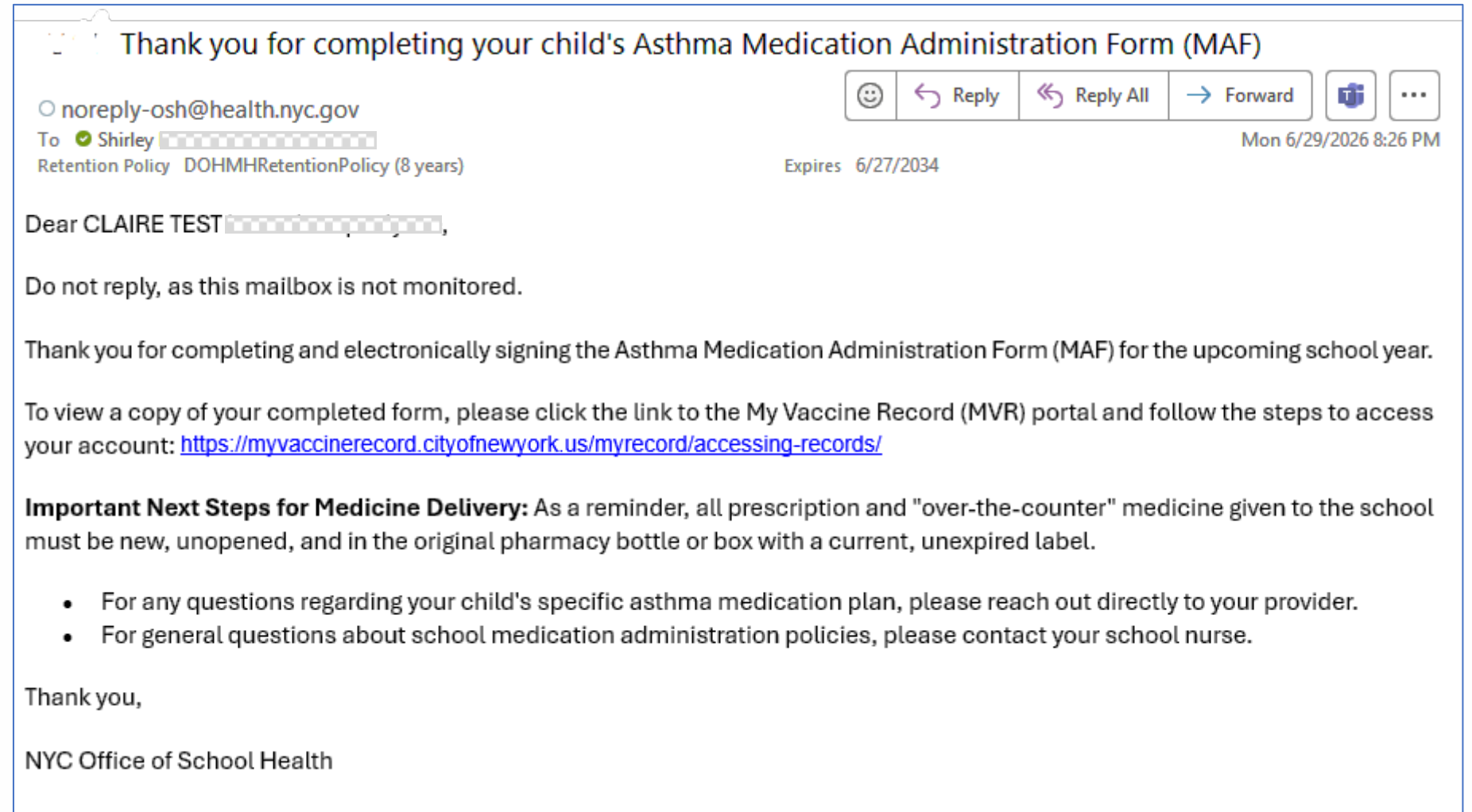


Thank you — your signature has been submitted successfully. Check your email for confirmation details.

Asthma MAF: Email confirmation of completed and signed form to parent

Parents can check for confirmation email sent from:

noreply-osh
@health.nyc.gov



CIR access for parents, legal guardians and individuals

My Vaccine Record: an online tool to look up immunization records for yourself or your child

<https://myvaccinerecord.cityofnewyork.us/myrecord/>

NEW! Completed Asthma Medication Administration Forms (Asthma MAF) for school can be downloaded and printed by parents from the search results page.

Promoting and Protecting the City's Health

NYC Health

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My Vaccine Record

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5 Feedback

Use this site to look up immunization records for yourself or your child.

To search for your or your child's immunization records online, you can use your IDNYC number, NYS Department of Motor Vehicle (DMV) Driver/Non-Driver License number, mobile phone, or email address. Learn more about how to [access records](#).

If your child's health care provider completed an Asthma Medication Administration Form (Asthma MAF) for school, a copy can be downloaded and printed from the records search results page.

If you are searching for a child's record, you must be listed on the birth certificate, or your child's health care provider must have reported your information to the City.

You will only be able to find your record if your health care provider has reported your immunizations to the City.

NYC health care providers are required to report all immunizations administered to children 0-18 years. Vaccinations administered to adults ages 19 and older may be reported with consent of the patient, according to New York State Public Health Law and the NYC Health Code. Immunization records for people born in NYC before 1995 may not have complete information.

Your immunization report is available as (1) a PDF document or (2) saved to your mobile phone as a SMART® Health Card using verifiable QR codes. Read more on the [SMART® Health Cards Info Page](#).

Next

If unable to retrieve a record online:

Complete the online [NYC Bureau of Immunization Record Assistance Request Form](#) and uploading a valid photo identification, such as Government-issued ID, Passport, or official photo ID. Staff will respond as quickly as possible, usually within 2 business days.

NYC Health

Immunization Record Request Application

Please print clearly.

Applicant's Information (Information for the person whose record is being requested)

First name

Middle name

Last name

Sex assigned at birth: ☐ Male ☐ Female

Date of birth (MM/DD/YYYY)

Phone number

Address

City

State

ZIP code

Instructions to request a record by mail

1. Complete the application.

2. Attach a copy of a valid photo ID, such as an IDNYC card, a driver's license, or a passport.

3. Mail the completed application and copy of the ID to:
NYC Health Department
Immunization Registry
42-49 28th St.
6th Floor, Cn-21
Long Island City, NY 11101-4132

You will receive a response within 10 business days. Do not email this application.

For more information or to request a print copy of this form, call 311, visit [nyc.gov/health](#) and search for vaccine records, or email [cir@health.nyc.gov](#)

For Official Use Only

Status of request:

☐ Record sent via email

☐ Record not found

☐ Record found - no vaccine

☐ Form incomplete

☐ Staff initials

Applicant's Mother Information

Mother's first name

Mother's last name

Mother's maiden name

Mother's date of birth (MM/DD/YYYY)

Parent or Guardian Information (If the person requesting the record is not the applicant)

Relationship to applicant: ☐ Mother ☐ Father ☐ Guardian ☐ Other (describe)

First name

Last name

Email address

This is to certify that I am the applicant, or the parent, guardian, or other person in a custodial relation to the applicant, and, as such, I am authorized to view the requested information. I understand that submitting false, untrue, or misleading information to the New York City Department of Health and Mental Hygiene is a violation of NYC Health Code § 24.15. I further understand that each incident of such violation is punishable by civil penalties up to \$2,000 pursuant to New York City Health Code § 24.11.

Signature of applicant or parent or guardian requesting the record

Date

Primary language of applicant or the parent or guardian requesting the record

 Citywide
Immunization
Registry

 NYC
Health

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My Vaccine Record (MVR) – Asthma MAF

After successfully completing the request for access and the record is retrieved, the parent may:

1. View the MAF by clicking on the arrow to open the for view,
2. Download and save the printable Asthma MAF form.

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My Vaccine Record

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4. Results

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To exit the current session, click "Home" in the menu above.

Your immunization report is available as (1) a PDF document or (2) saved to your mobile phone as a SMART® Health Card using verifiable QR codes.

PDF Reports

Immunization Record PDF

This report contains immunization data that have been reported to the Health Department's Citywide Immunization Registry (CIR). Review this report with your health care provider for completeness and accuracy.

The PDF printout includes QR codes that may be scanned into a SMART® Health Card application at your convenience.

Preview Immunization Record PDF

Download Immunization Record PDF

Asthma Medication Administration Form (Asthma MAF) PDF

This record displays the Asthma Medication Administration Form (Asthma MAF) data that has been electronically submitted by your child's health care provider to the Office of School Health (OSH).

Please review this information carefully to ensure your child's medication names, dosages, and administration schedules are completely accurate. If you notice any discrepancies or if your child's asthma management plan has changed, please contact your health care provider immediately to submit an updated clinical order.

Preview Asthma Medication Administration Form PDF

ADULT
GUARDIAN
PRINT NAME

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2026-2027

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

Student Last Name: TESTFirst Name: ERINMiddle Initial: TDate of Birth: 03/07/2015

Sex: ☐ Male ☒ FemaleOSIS Number: 333333333Grade: 1Class: 33333DOE District: 24

School (include ATS DBN Name, address, and borough): 24728 - CATHEDRAL PREPARATORY SCHOOL AND SEMINARY, 56-25 92ND ST, Q

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis ☒ Asthma ☒ Other test

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

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

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

☒ Y ☐ N ☐ UHistory of life-threatening asthma (loss of consciousness, hypoxic seizure, or intubation)

☒ Y ☐ N ☐ UHistory of asthma-related PICU admissions (ever)

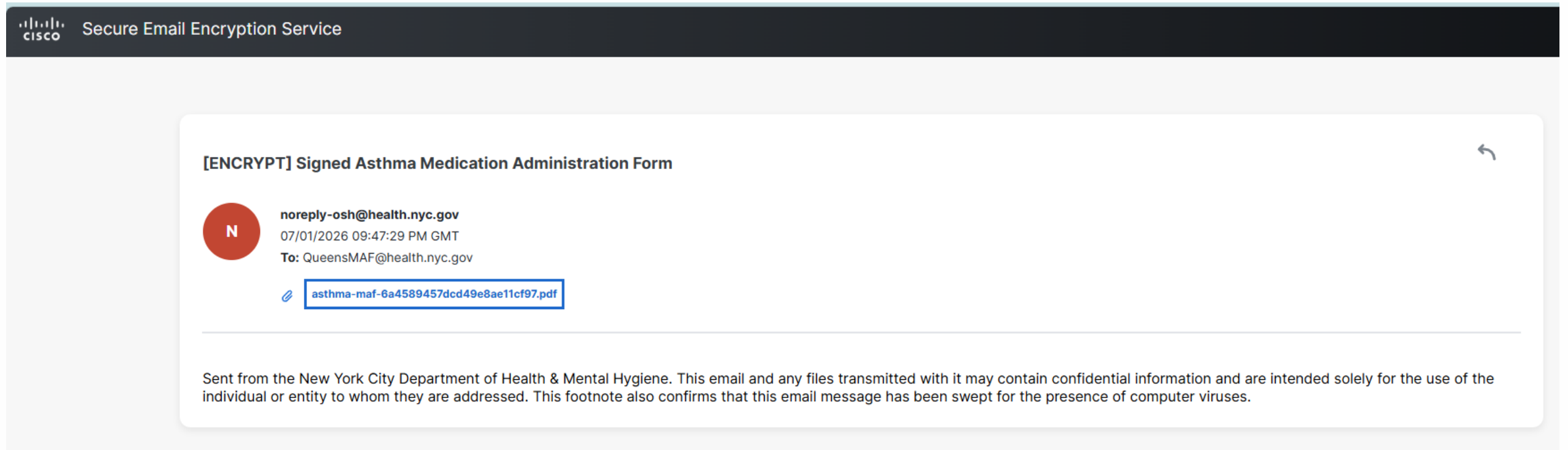
☒ Y ☐ N ☐ UReceived oral steroids within past 12 months: 12 times last: 06/28/2026

☒ Y ☐ N ☐ UHistory of asthma-related ER visits within past 12 months: 12 times last: 06/28/2026

Download Asthma Medication Administration Form PDF

Asthma-MAF: School District Office email copy

A copy of the signed Asthma MAF is sent to the child's school district office email box.



Set Up: Customize Settings

- **Default Settings**
- MyList Settings
- Search Settings
- **Precompleted Forms Settings**
- Doses Administered Report Settings
- Reminder/Recall Facility Name and Contact Settings
- **Change password/email**
- No longer used. Switched to SSO accounts. Contact your Facility SSA to update email. SSA's can contact **CIR**.
- **Manage Users** (SSA access only)

Online Registry

PATIENTS Search MyList Reports Add/Edit **PRACTICE** Tools Dashboards Recall Adv. Event MM Set Up QuickAdd ? Help

Welcome Emily
Facility: RECAI
Address: TEST

[Default Settings](#) [Change Password/Email](#) [Manage Users](#)

Update Settings

MyList Settings

Initial view: Show **My List**

Display: Show **10** patients per page

Sort: **Last Accessed**

Search Settings

Always start with:
☒ Simple Search
☐ Advanced Search

Show this Advanced Search:
☐ Medical Record No.
☐ Medicaid
☐ CIR No.
☐ Mom DOB
☐ Other Demographics
☒ Show All Fields

Precompleted Forms Settings

You may edit the information below to change the provider information that is pre-populated on the pre-completed forms that you generate.

Phone: () -

Fax: () -

Email:

Provider Last Name: First: License Type: (Select) License No:

Note: To ensure that this information is saved, or request to update facility information, including address, please contact the CIR at 347-396-2400.

Doses Administered Report Settings

Always start with:
☒ Summary Report
☐ Detailed Report

Reminder/Recall Facility Name and Contact Settings

Enter your facility name and phone number as you would like it to appear to the patient for reminder/recall purposes. Entries may be edited for specific jobs.

Facility Name (up to 30 characters): :

Facility Contact #: () -

Confirm ✓

Citywide Immunization Registry

NYC Department of Health and Mental Hygiene

General CIR contact information:

Tel: 347-396-2400

Fax: 347-396-8840

nyc.gov/health/cir

E-mail: cir@health.nyc.gov

with subject line: Online Registry Asthma MAF training