New York City
Citywide Immunization Registry (CIR)

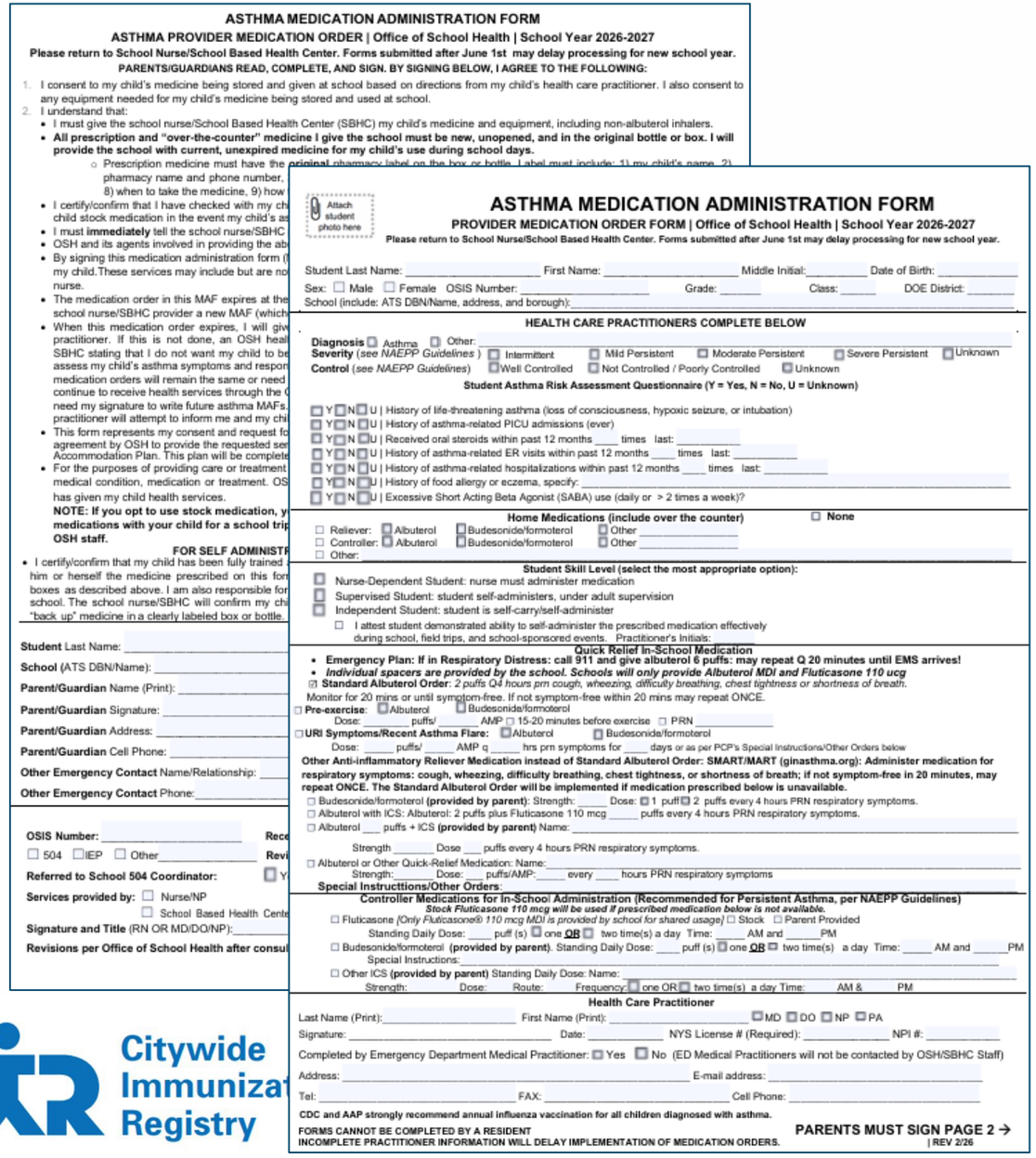
Online Registry –
Asthma Medication Administration Form
(Asthma MAF) Guide

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

Citywide Immunization Registry

NYC Health

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 original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 8) when to take the medicine, 9) how
   - I certify/confirm that I have checked with my ch 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 (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 giv practitioner. If this is not done, an OSH healt SBHC stating that I do not want my child to be assess my child's asthma symptoms and respon medication orders will remain the same or need continue to receive health services through the 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 ser 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 ADMINISTR

- 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.

Student Last Name: _____

School (ATS DBN/Name): _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

Parent/Guardian Address: _____

Parent/Guardian Cell Phone: _____

Other Emergency Contact Name/Relationship: _____

Other Emergency Contact Phone: _____

OSIS Number: _____ Rec

☐ 504 ☐ IEP ☐ Other_____ Revi

Referred to School 504 Coordinator: ☐ Y

Services provided by: ☐ Nurse/NP

☐ School Based Health Cente

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

Revisions per Office of School Health after consul

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 DBN/Name, address, and borough):_____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis ☐ Asthma ☐ Other: _____

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 ☐ 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) ☐ None

☐ 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: 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**: *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 ☐ Budesonide/formoterol
Dose: _____ puffs/ _____ AMP ☐ 15-20 minutes before exercise ☐ PRN _____

☐ **URI Symptoms/Recent Asthma Flare:** ☐ Albuterol ☐ Budesonide/formoterol
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 Instructtions/Other Orders: _____

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: _____ AM and _____PM
☐ Budesonide/formoterol **(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
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: _____

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 →

| REV 2/26

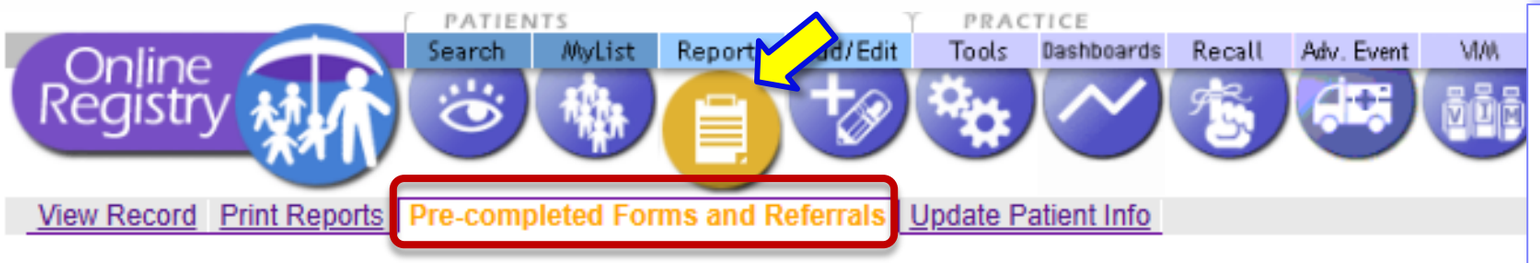
The **Asthma Medication Administration Form (Asthma MAF)** is a provider medication order for the Office of School Health.

- 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.**

Citywide Immunization Registry

NYC Health

Asthma MAF: Online Registry Pre-completed Form



- *NEW* If applicable for this patient, view latest available risk assessment and home inspection results here, or make a r
  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 availab
  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 Acro
  PDF format.** You may edit fillable fields on the form, and then print the forms to give to the parent or guardian of the c
  *NOTE: For best results, you may need to download or update your current version of Adobe Reader (we recommend
  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 cons
can also directly refer their child for early intervention using the NYC EI Referral Portal, or they can call 311 and ask for "E
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.

GO *NEW* Healthy Homes P
and/or Mold Referral Fo
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.

To fill out the electronic asthma MAF:

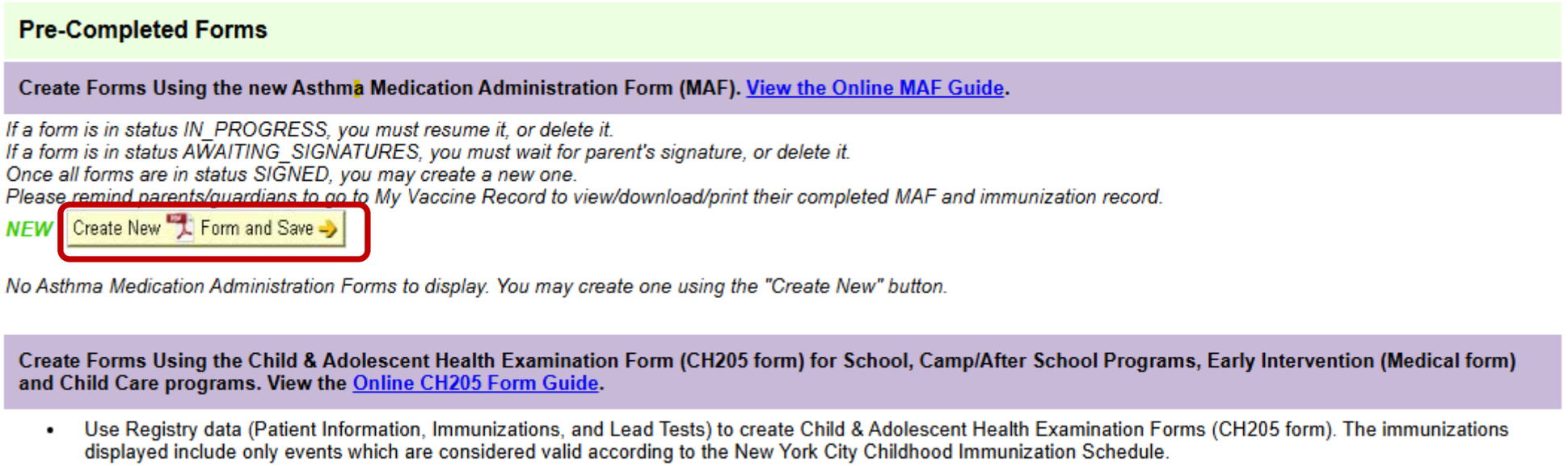
- Go to Reports, then click the **Pre-completed Forms and Referrals tab**
- Scroll to bottom of page to **Pre-Completed Forms**

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

For additional information please refer to our CIR Full Guide

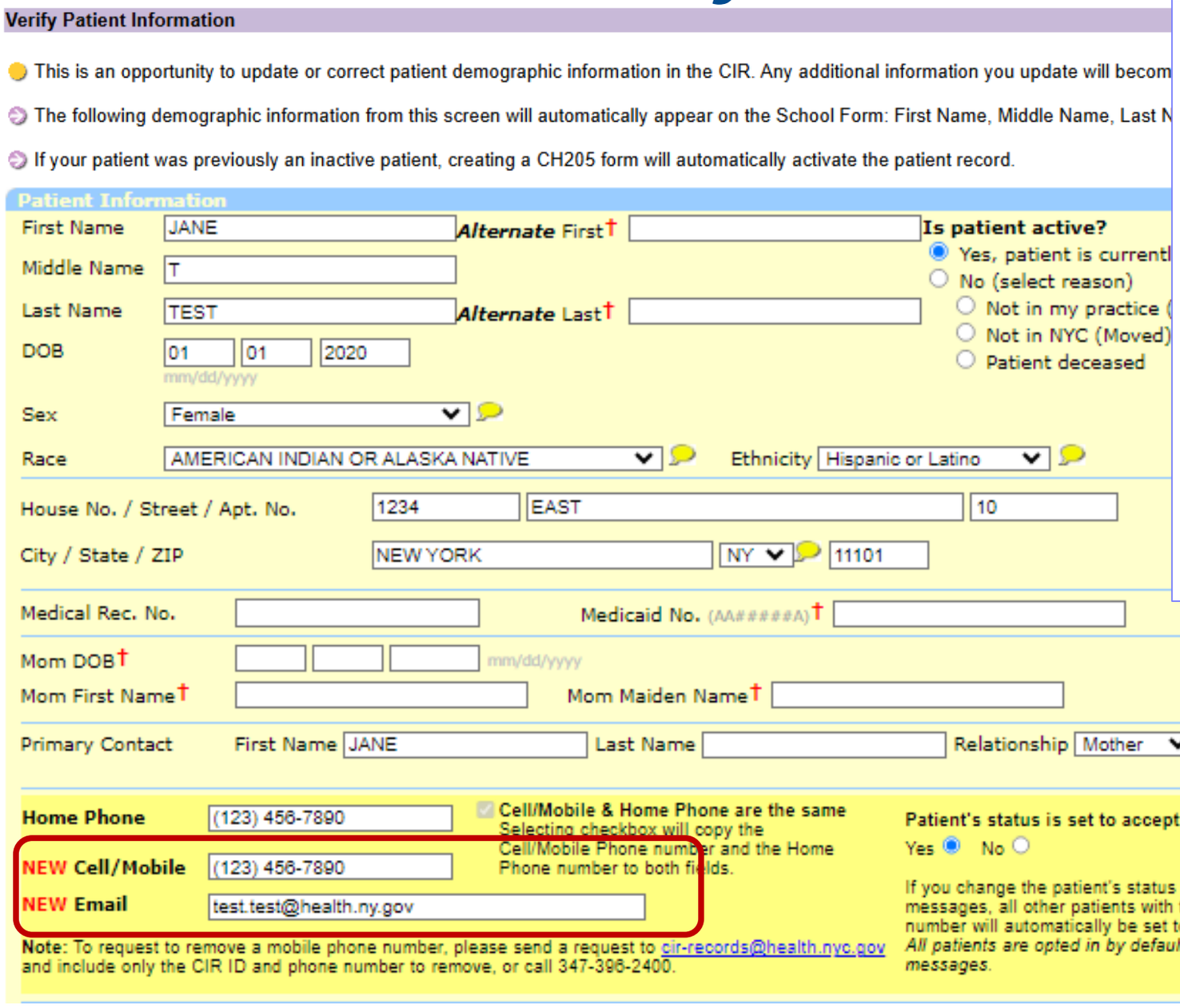
Asthma MAF: Create New Form



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 Create New Form and Save to begin filling out the asthma MAF.

Asthma MAF: Verify Patient Information



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.

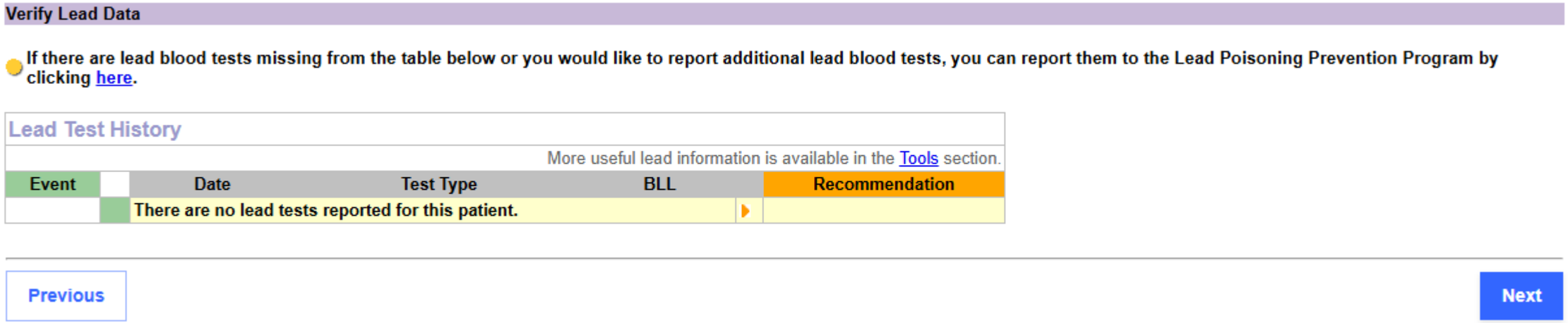
Immunization History

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.

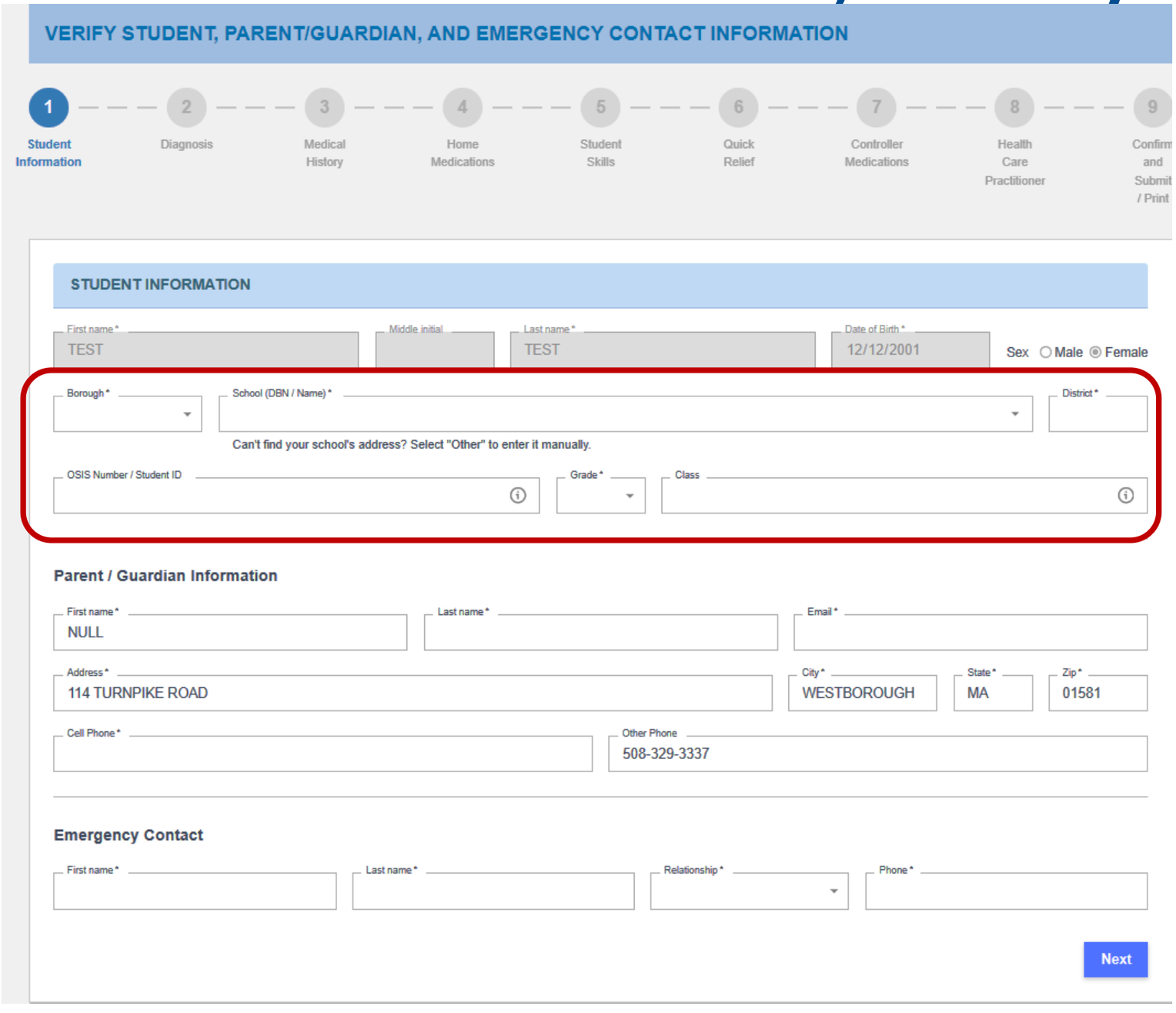
Asthma MAF: Verify Lead Data



Verify 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

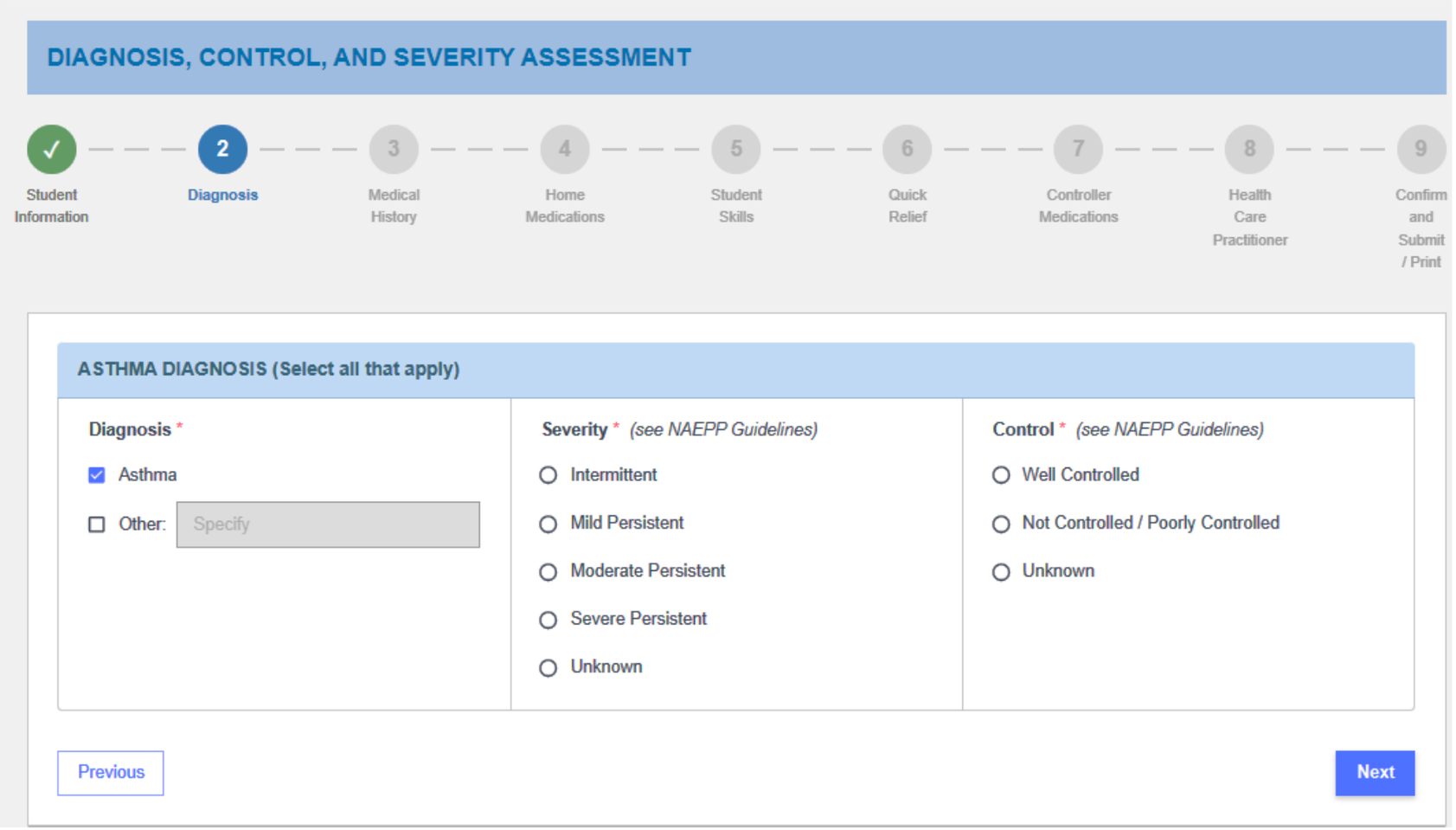


In the form, first verify the patient/student information:

- 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

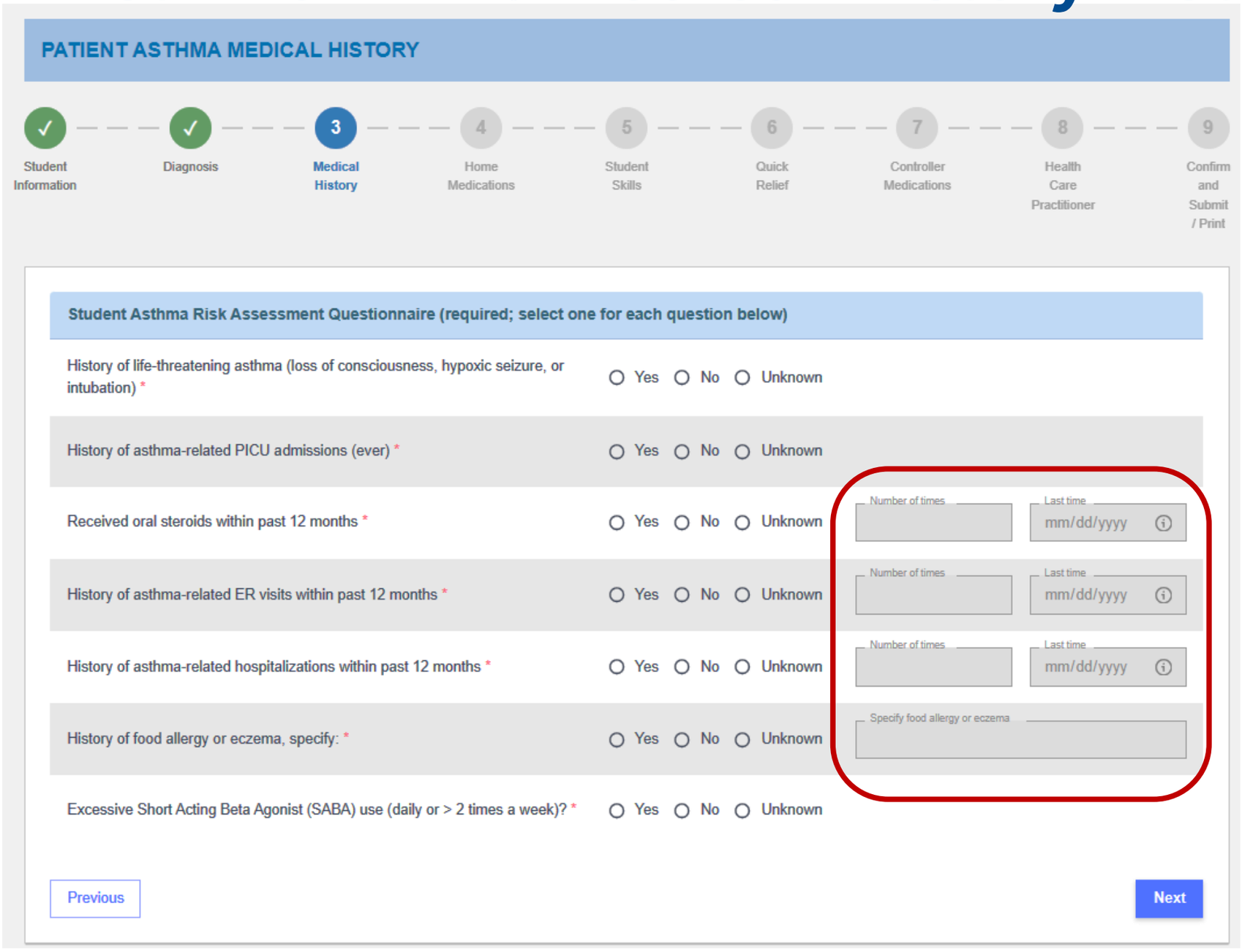


Next is to provide the student's diagnosis.

- 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

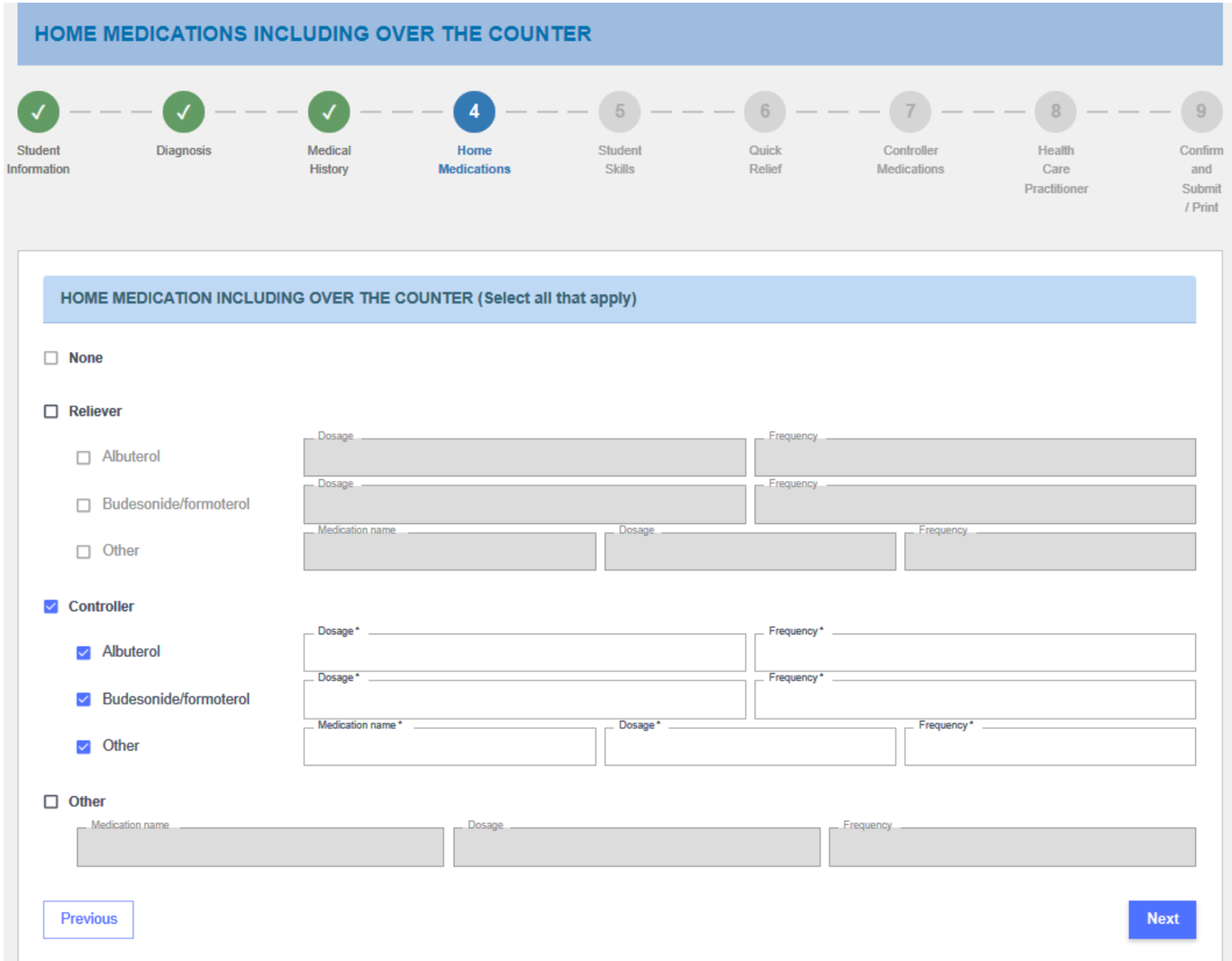


Next is to provide the student's medical history, by completing the **Student Asthma Risk Assessment Questionnaire**.

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

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

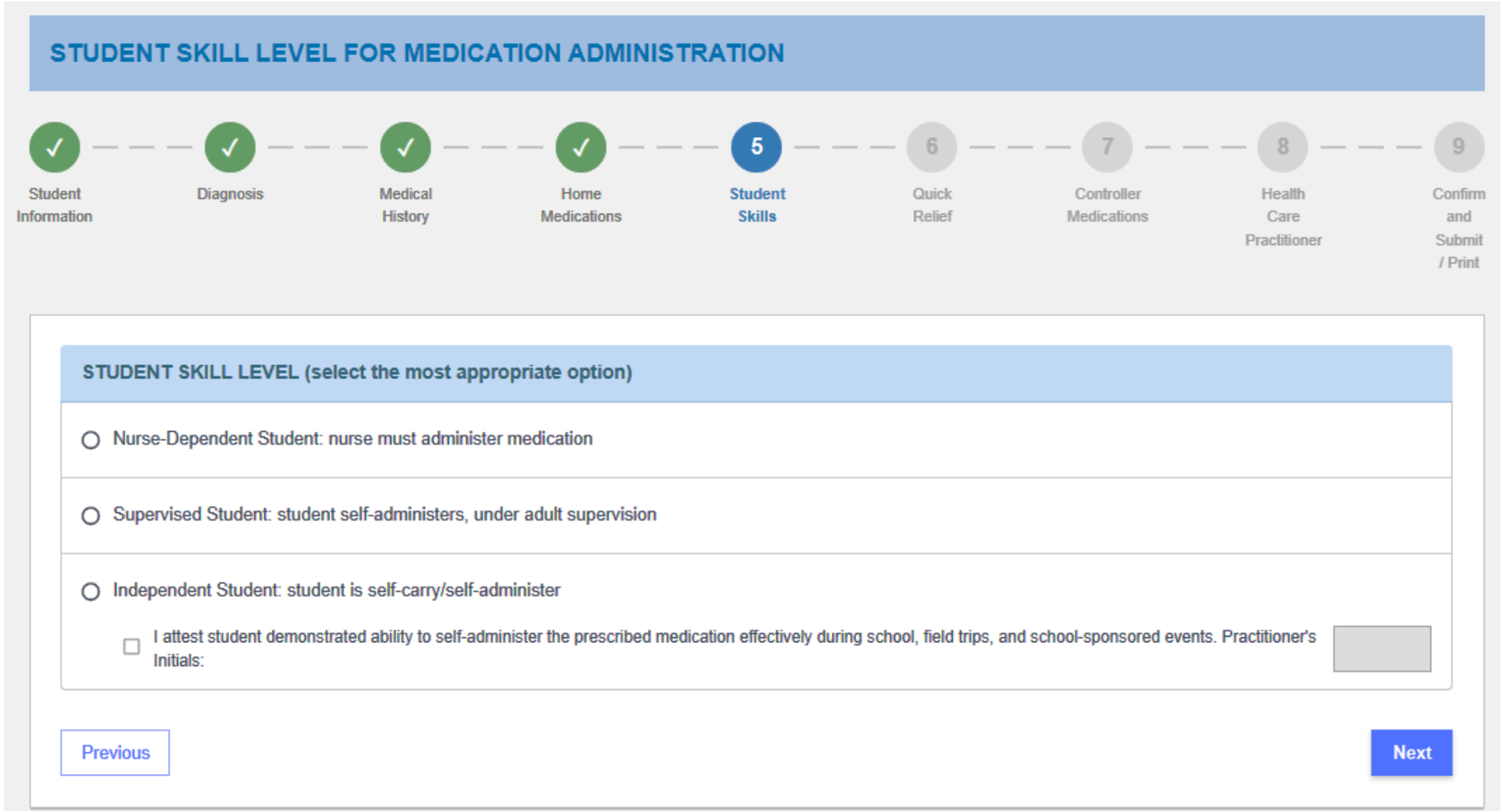
Asthma MAF: Home Medications - Step 4



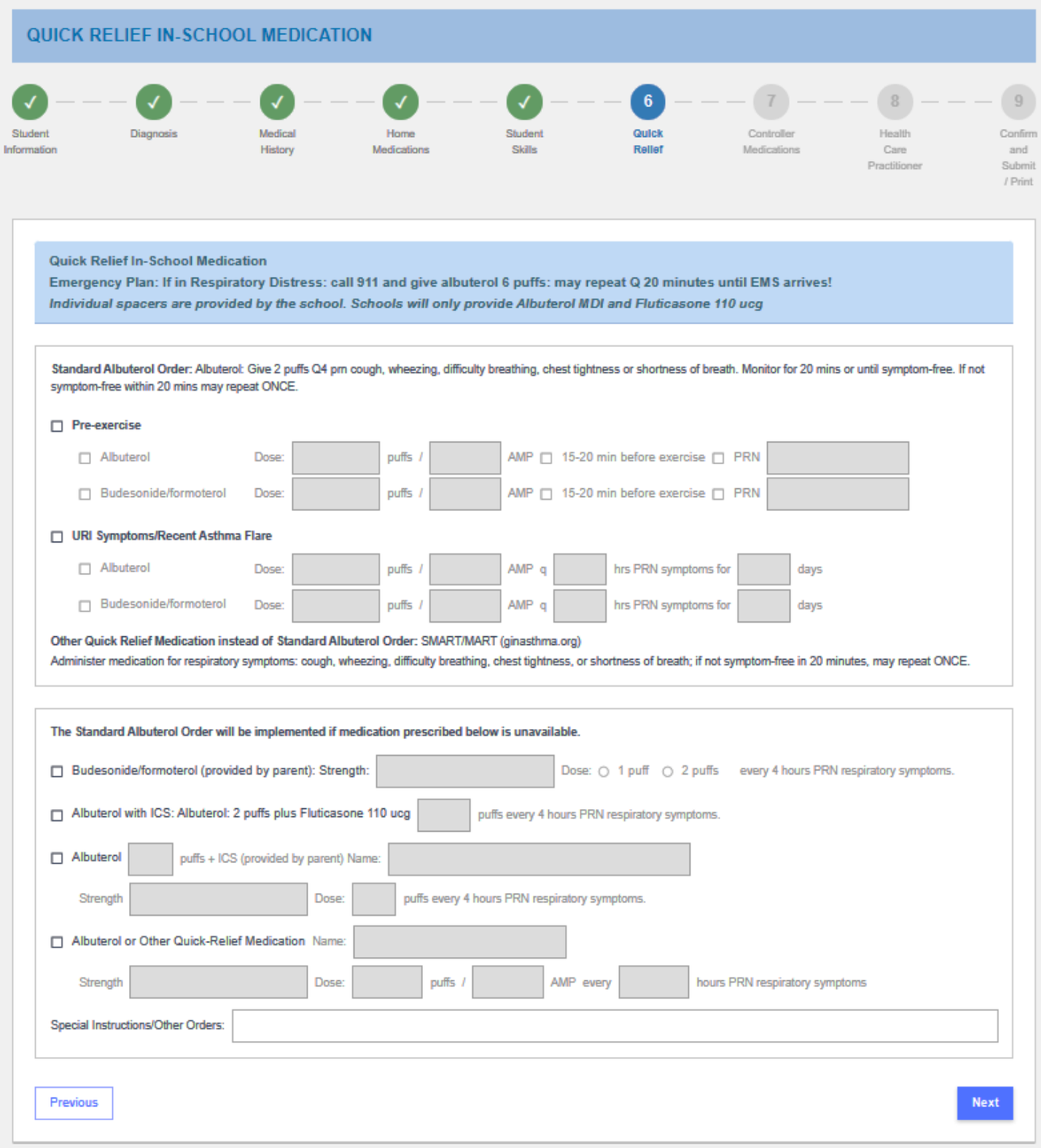
Under **Home Medications**, enter all the medications a patient is taking for their asthma at home.

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

Asthma MAF: Student Skills – Step 5



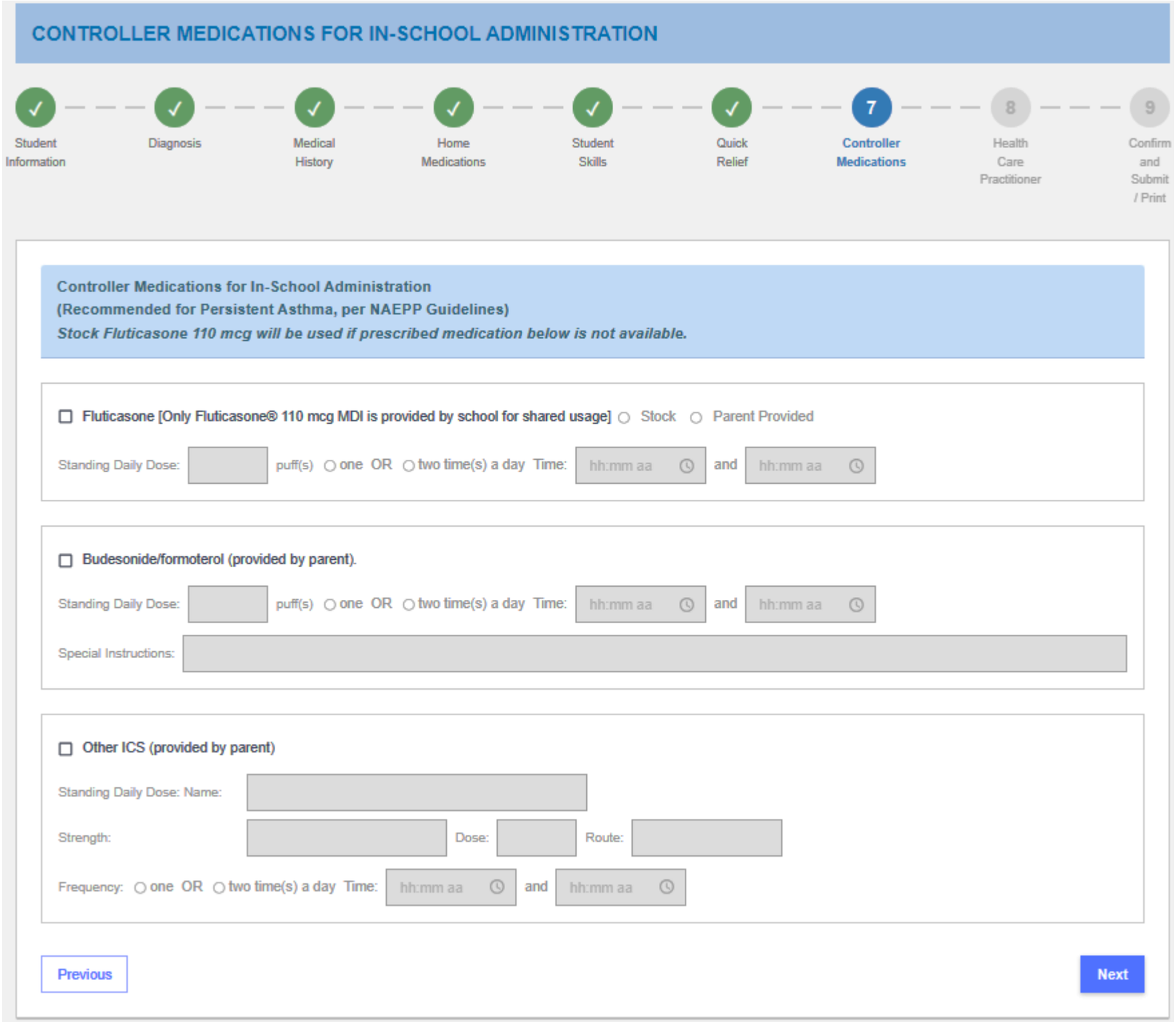
The **Student Skill Level** section is for providers to attest how much support students need when administering their medication.



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.



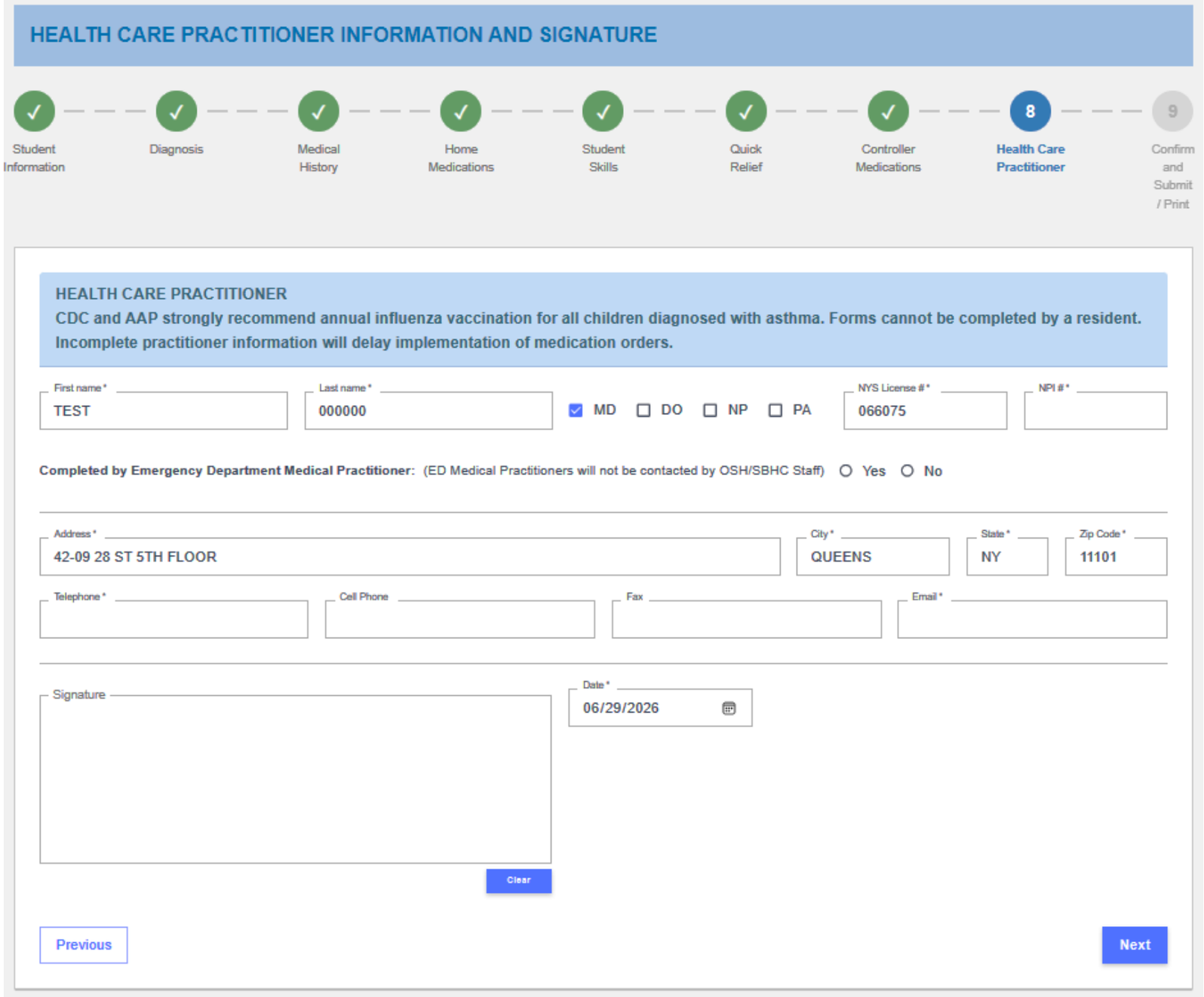
Asthma MAF: Controller Medication-Step 7

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.

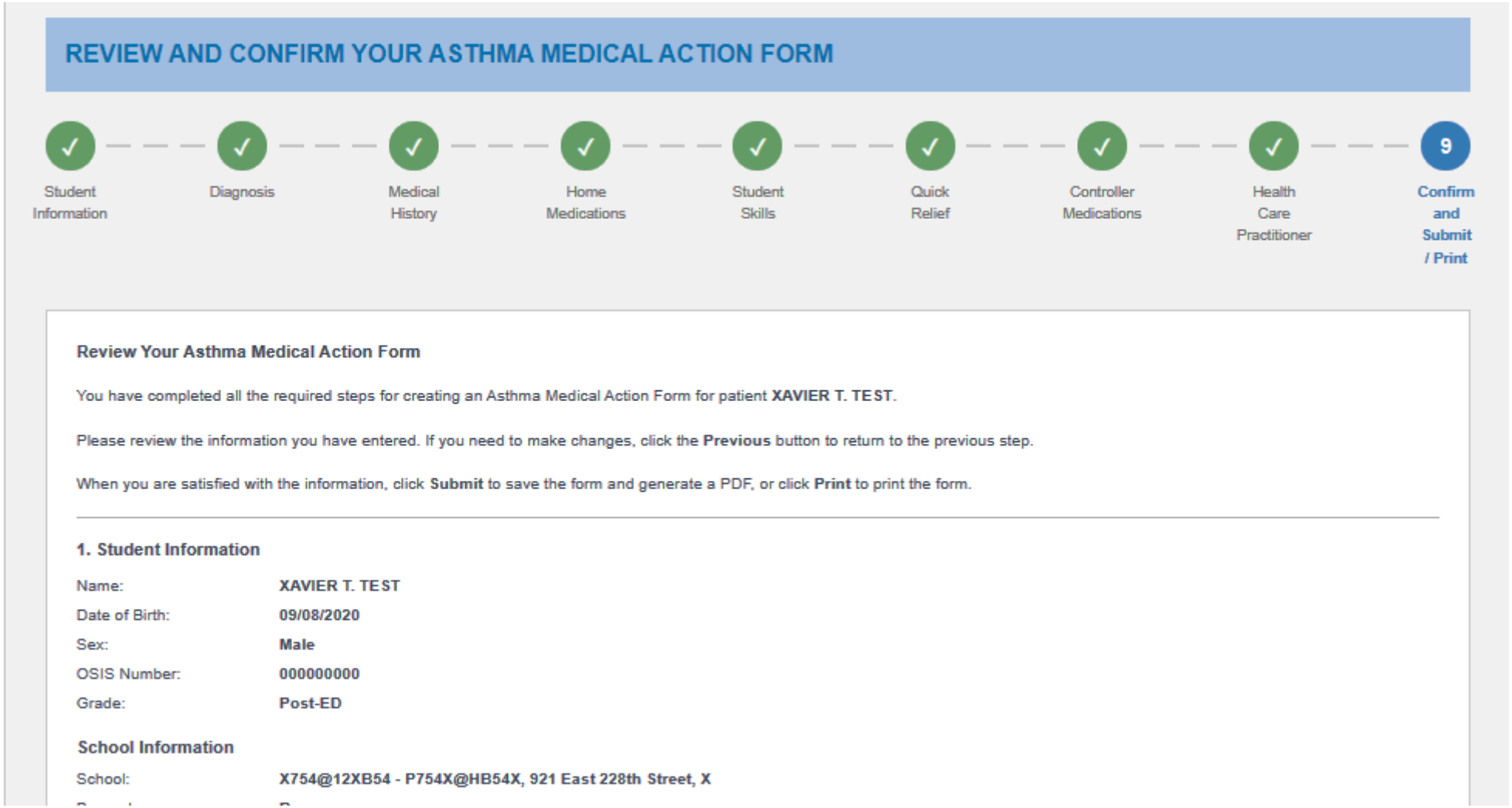
Asthma MAF – Health Care Practitioner Signature – Step 8



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.

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

Reply | Reply all | Forward
Thu 6/11/2026 10:07 AM

Retention: DOHMHRetentionPolicy (8 years) Expires: Fri 6/9/2034 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.

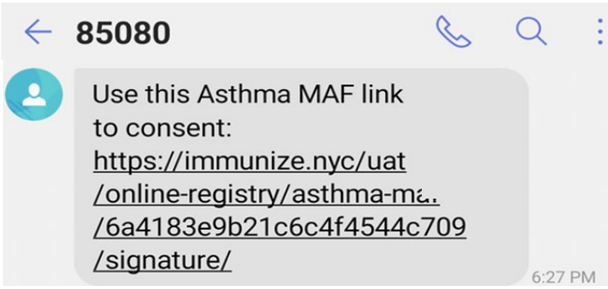
Please click this link to consent: https://immunize.nyc/uat/online-registry/asthma-maf/6a0f0ddd6b5ecc2ae25c36ac/signature/

Thank you,

NYC Office of School Health

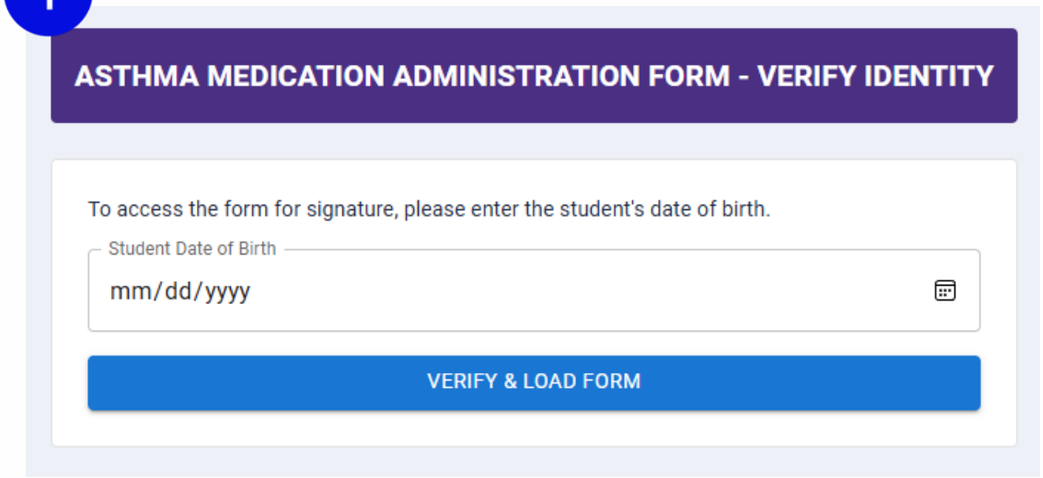
The parent listed on the form receives a **Consent to Order** by email. The link allows the parent to review the contents of the order and to sign the **Online Parent Signature form.**

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

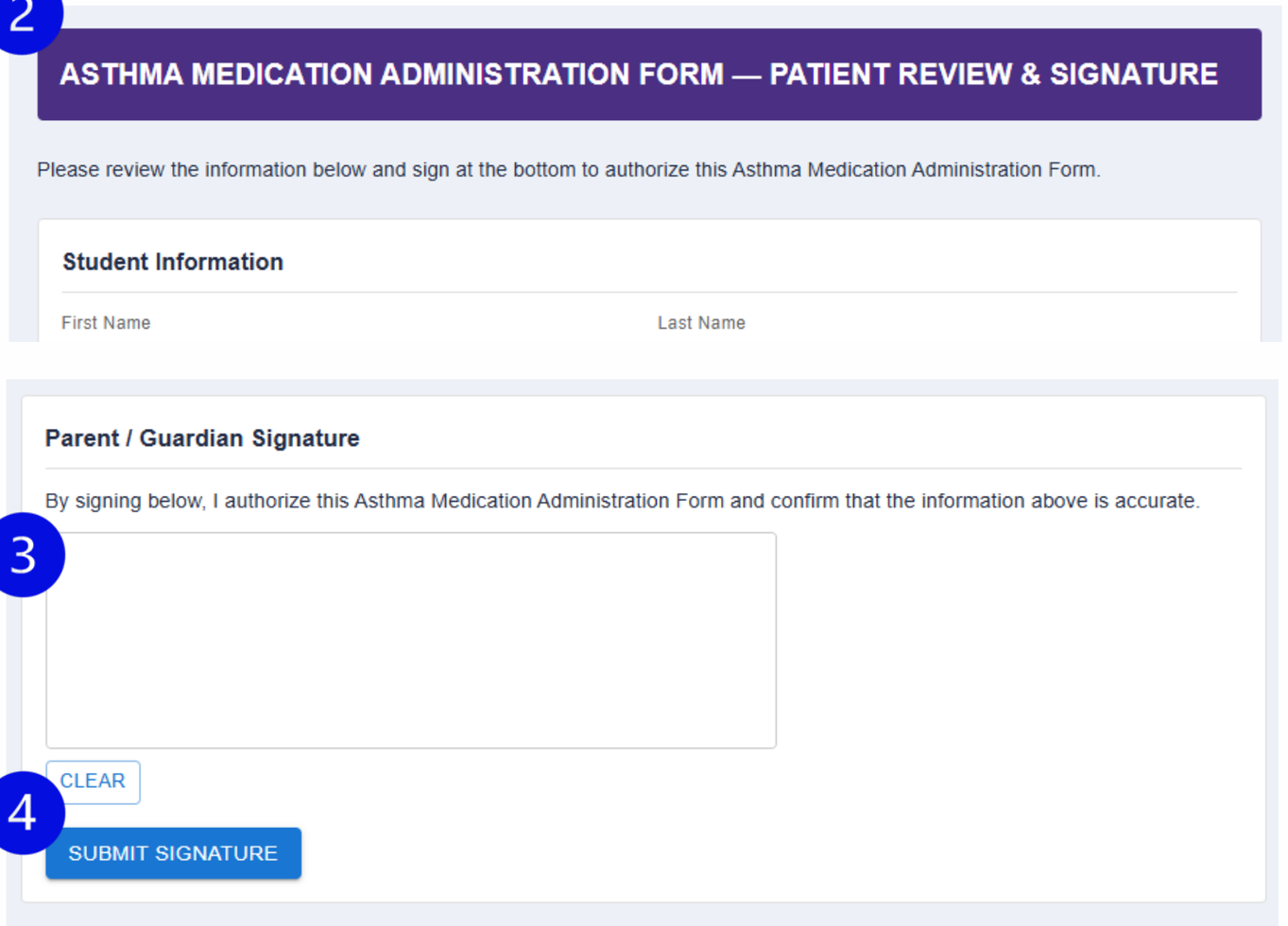


Asthma MAF: Online Parent Signature form

1

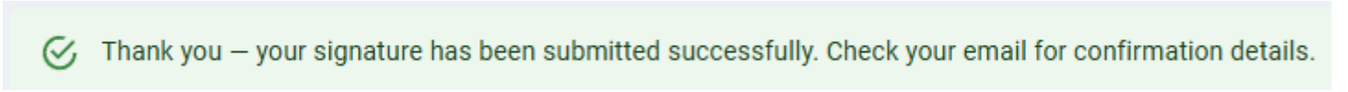


2



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

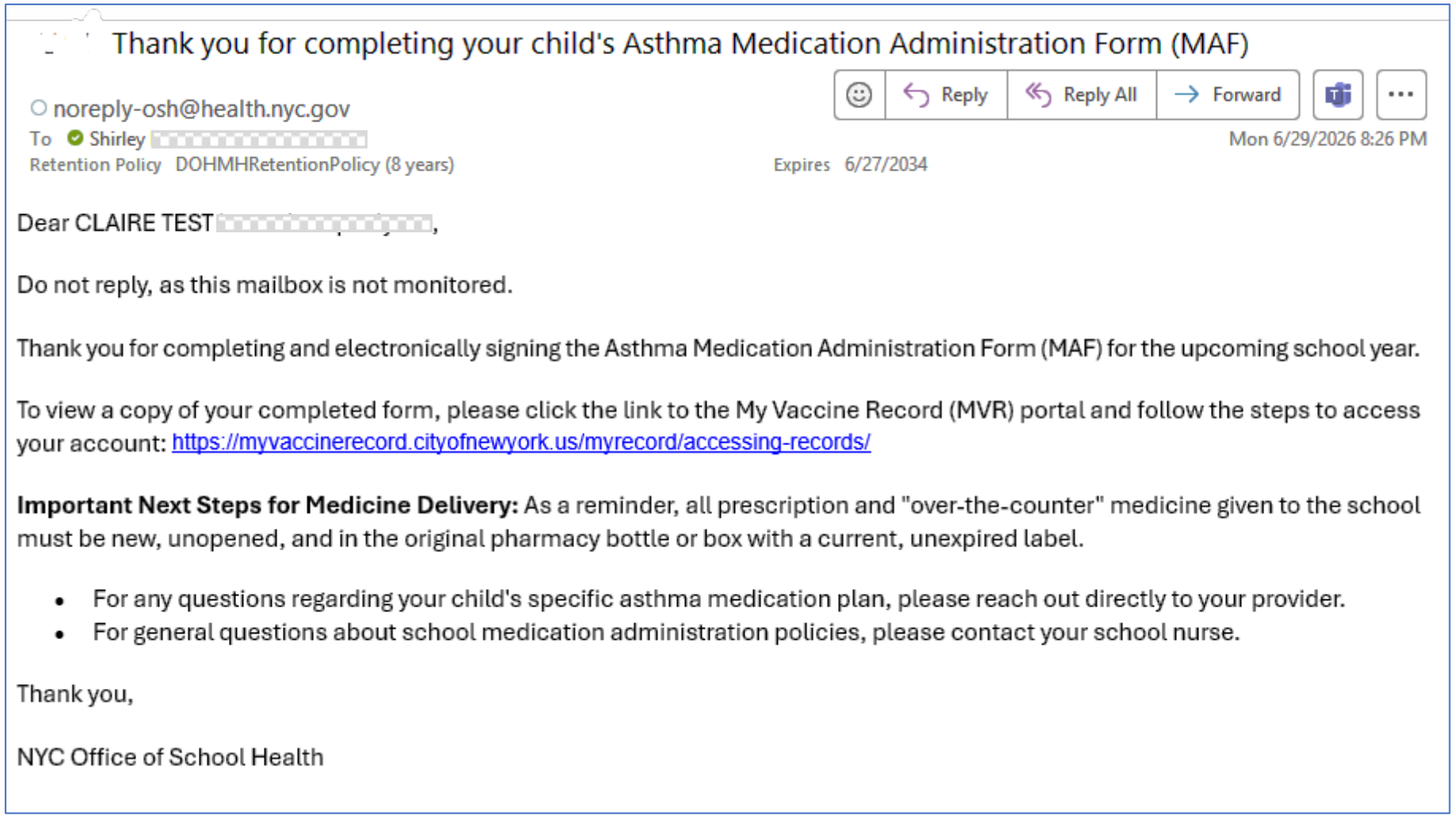
A copy of the form will be sent to the school district by email from noreply-osh@health.nyc.gov



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

Parents can check for confirmation email sent from:

noreply-osh @health.nyc.gov



Thank you for completing your child's Asthma Medication Administration Form (MAF)

Reply | Reply All | Forward

noreply-osh@health.nyc.gov

To Shirley [redacted]

Mon 6/29/2026 8:26 PM

Retention Policy DOHMHRetentionPolicy (8 years) Expires 6/27/2034

Dear CLAIRE TEST [redacted],

Do not reply, as this mailbox is not monitored.

Thank you for completing and electronically signing the Asthma Medication Administration Form (MAF) for the upcoming school year.

To view a copy of your completed form, please click the link to the My Vaccine Record (MVR) portal and follow the steps to access your account: https://myvaccinerecord.cityofnewyork.us/myrecord/accessing-records/

Important Next Steps for Medicine Delivery: As a reminder, all prescription and "over-the-counter" medicine given to the school must be new, unopened, and in the original pharmacy bottle or box with a current, unexpired label.

- For any questions regarding your child's specific asthma medication plan, please reach out directly to your provider.
- For general questions about school medication administration policies, please contact your school nurse.

Thank you,

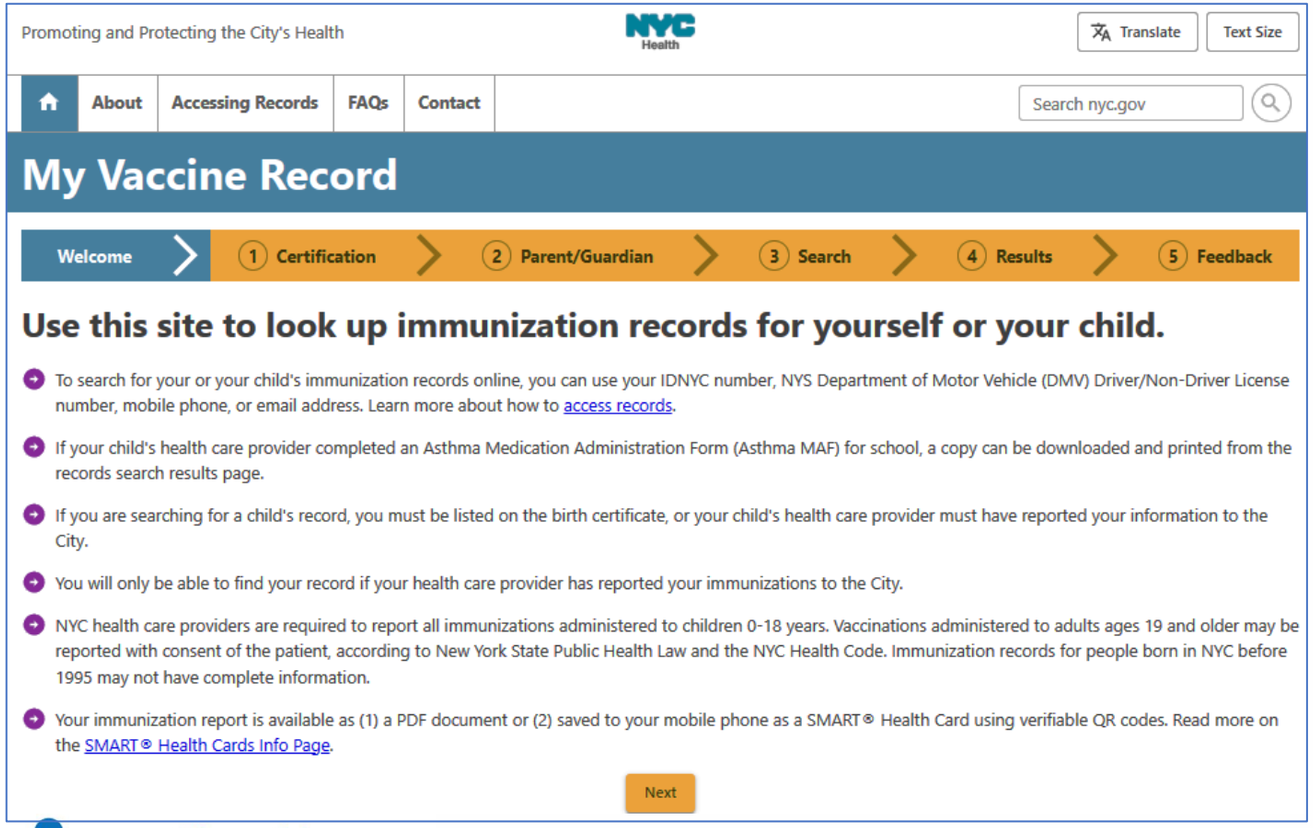
NYC Office of School Health

CIR access for parents, legal guardians and individuals

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

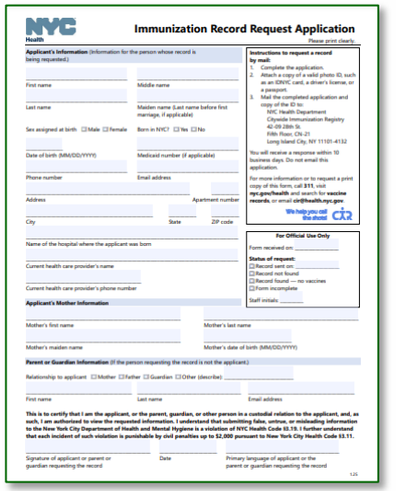
https://myvaccinerecord.cityofnewyork.us/myrecord/

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



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.



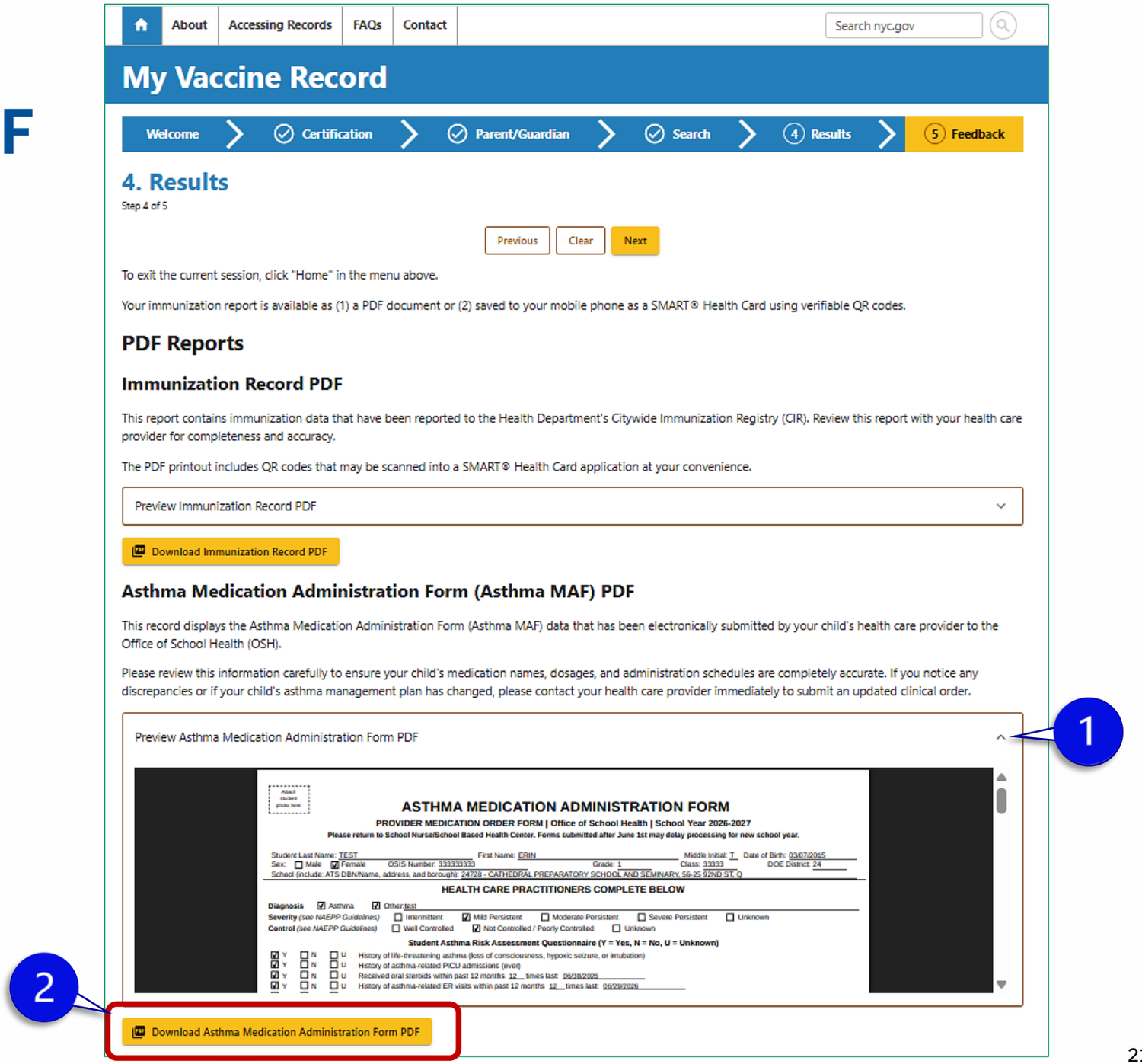
Citywide Immunization Registry

NYC Health

My Vaccine Record (MVR) – Asthma MAF

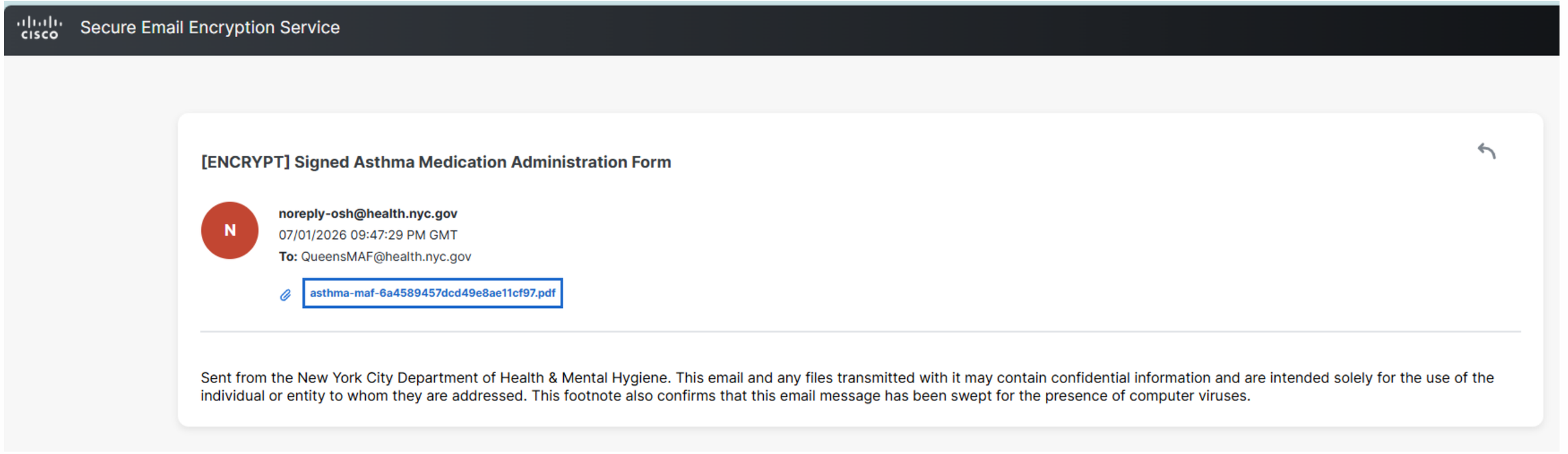
After successfully completing the request for access and the record is retrieved, the parent may:

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



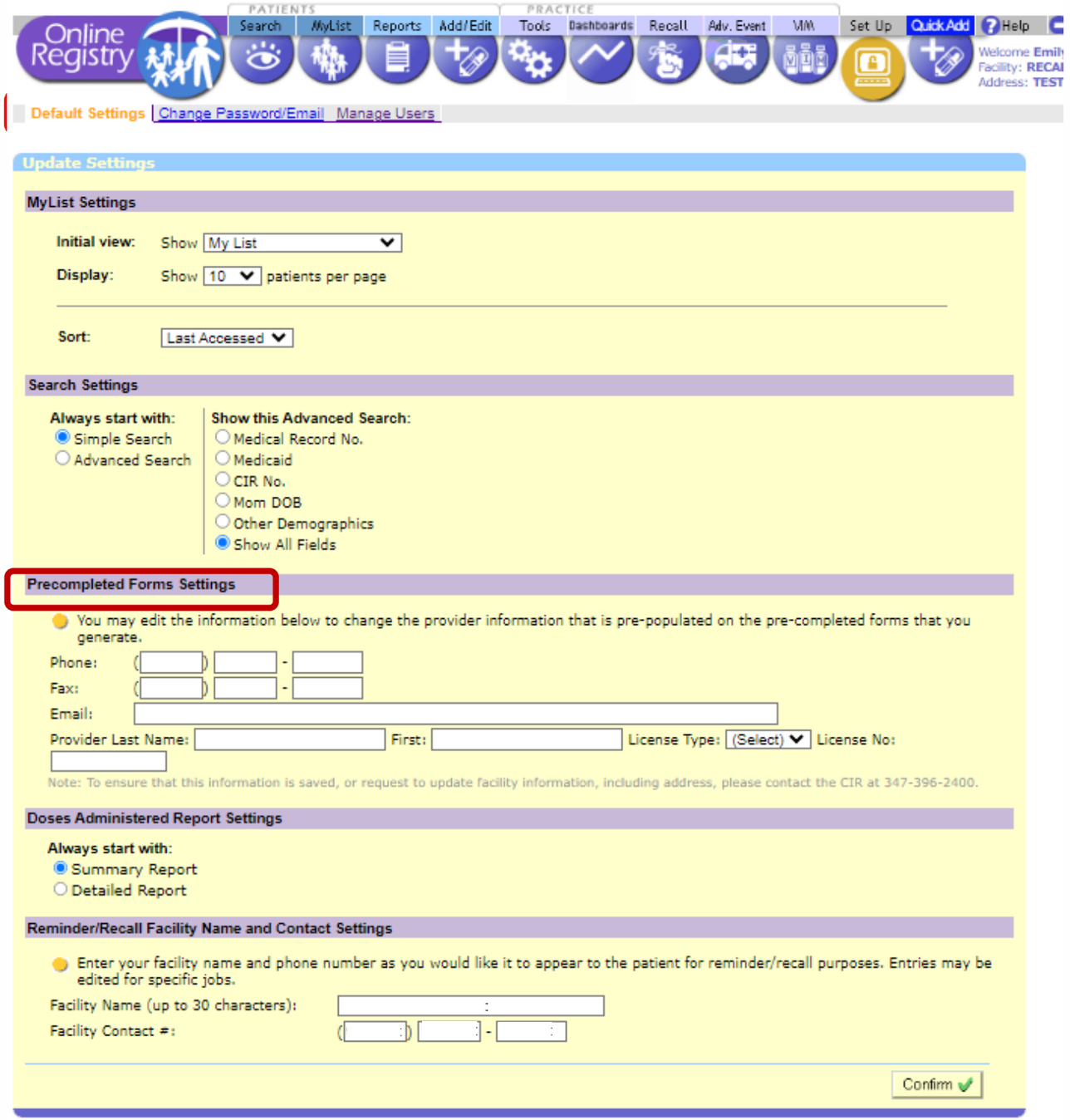
Asthma-MAF: School District Office email copy

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)



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