



DIABETES MEDICATION ADMINISTRATION FORM [PART A]

Provider Medication Order Form – Office of School Health – School Year 2020-2021

DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. Please fax all DMAFs to 347-396-8932/8945.

Student Last Name	First Name	MI	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	OSIS #
School (include ATSDBN/name, address and borough)			DOE District	Grade	Class

HEALTH CARE PRACTITIONER COMPLETES BELOW [Please see 'Provider Guidelines for DMAF Completion']

Type 1 Diabetes Type 2 Diabetes Non-Type 1/Type 2 Diabetes Other Diagnosis: _____
 Recent A1C: Date ____/____/____ Result ____%.

Orders written will be for Sept. '20 through Aug '21 school year unless checked here: Current School Year '19-'20 and '20-'21

EMERGENCY ORDERS

<p>Severe Hypoglycemia Administer Glucagon and call 911 Glucagon: <input type="checkbox"/> 1 mg <input type="checkbox"/> ____ mg SC/IM GVOKE: <input type="checkbox"/> 1 mg <input type="checkbox"/> ____ mg SC/IM Baqsimi: <input type="checkbox"/> 3 mg Intranasal</p> <p>Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration.</p>	<p>Risk for Ketones or Diabetic Ketoacidosis (DKA) <input type="checkbox"/> Test ketones if bG > ____ mg/dl, or if vomiting, or fever > 100.5F OR <input type="checkbox"/> Test ketones if bG > ____ mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5F</p> <p>> If <u>small or trace</u> give water; re-test ketones & bG in 2 hrs or ____ hrs > If ketones are <u>moderate or large</u>, give water: Call parent and Endocrinologist; <input type="checkbox"/> NO GYM If ketones and vomiting, unable to take PO and MD not available, CALL 911</p> <p><input type="checkbox"/> Give insulin correction dose if > 2 hrs or ____ hours since last insulin.</p>
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SKILL LEVEL

<p>Blood Glucose (bG) Monitoring Skill Level</p> <p><input type="checkbox"/> Nurse / adult must check bG. <input type="checkbox"/> Student to check bG with adult supervision. <input type="checkbox"/> Student may check bG without supervision.</p>	<p>Insulin Administration Skill Level</p> <p><input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised student: student self-administers, under adult supervision</p>	<p><input type="checkbox"/> Independent Student: Self-carry / Self-administer (<i>MUST Initial attestation</i>) I attest that the independent student demonstrated the ability to self-administer the prescribed medication effectively for school, field trips, & school/sponsored events</p> <p style="text-align: right;">PROVIDER INITIALS _____</p>
NOTE: Trip nurse not required for supervised or independent students.		

BLOOD GLUCOSE MONITORING [See Part B for CGM readings]

Specify times to test in school (must match times for treatment and/or insulin) Breakfast Lunch Snack Gym PRN

Hypoglycemia: Check all boxes needed. Must include at least one treatment plan.

For bG < ____ mg/dl give ____ gm rapid carbs at: Breakfast Lunch Snack Gym PRN T2DM - no bG monitoring or insulin in school
 Repeat bG testing in 15 or ____ min. If bG still < ____ mg/dl repeat carbs and retesting until bG > ____ mg/dl.

For bG < ____ mg/dl give ____ gm rapid carbs at: Breakfast Lunch Snack Gym PRN
 Repeat bG testing in 15 or ____ min. If bG still < ____ mg/dl repeat carbs and retesting until bG > ____ mg/dl.

For bG < ____ mg/dl pre-gym, **no gym** For bG < ____ mg/dl Pre-gym; PRN; treat hypoglycemia then give snack. 15 gm rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz.

Insulin is given before food unless noted here: Give insulin after: Breakfast Lunch Snack Snack orders on DMAF Part B

Mid-range Glycemia: *Insulin is given before food unless noted here:* Give insulin after: Breakfast Lunch Snack Give snack before gym

Hyperglycemia: *Insulin is given before food unless noted here:* Give insulin after: Breakfast Lunch Snack

No Gym For bG > ____ mg/dl Pre-gym and/or PRN

For bG > ____ mg/dl PRN, Give insulin correction dose if > 2 hrs or ____ hrs. since last insulin For bG meter reading "High" use bG of 500 or ____ mg/dl.

Check bG or Sensor Glucose (sG) before dismissal Give correction dose pre-meal and carb coverage after meal

For sG or bG values < ____ mg/dl treat for hypoglycemia if needed, and give ____ gm carb snack before dismissed
 For sG or bG values < ____ mg/dl treat for hypoglycemia if needed, and do not send on bus/mass transit, parent to pick up from school.

INSULIN ORDERS

<p>Name of Insulin*: _____</p> <p>* May substitute Novolog with Humalog/Admelog <input type="checkbox"/> No Insulin in School <input type="checkbox"/> No Insulin at Snack</p> <p>Delivery Method: <input type="checkbox"/> Syringe/Pen <input type="checkbox"/> Pump (Brand): _____ <input type="checkbox"/> Smart Pen – use pen suggestions</p>	<p>Insulin Calculation Method:</p> <p><input type="checkbox"/> Carb coverage ONLY at: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Correction dose ONLY at: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Carb coverage plus correction dose when bG > Target AND at least 2 hrs or ____ hrs. since last insulin at <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack Correction dose calculated using: <input type="checkbox"/> ISF or <input type="checkbox"/> Sliding Scale <input type="checkbox"/> Fixed Dose (see Other Orders) <input type="checkbox"/> Sliding Scale (See Part B) <input type="checkbox"/> If gym/recess is immediately following lunch, subtract ____ gm carbs from lunch carb calculation.</p>	<p>Insulin Calculation Directions: (give number, not range)</p> <p>Target bG = ____ mg/dl Insulin to Carb Ratio (I:C): _____</p> <p>Insulin Sensitivity Factor (ISF): _____ 1 unit decreases bG by ____ mg/dl (time: ____ to ____) 1 unit decreases bG by ____ mg/dl: (time: ____ to ____)</p> <p><i>If only one ISF, time will be 8am to 4pm if not specified.</i></p> <p>Bkfst OR time: ____ to ____ 1 unit per ____ gms carbs</p> <p>Snack OR time: ____ to ____ 1 unit per ____ gms carbs</p> <p>Lunch OR time: ____ to ____ 1 unit per ____ gms carbs</p> <p>Lunch followed by gym 1 unit per ____ gms carbs</p>
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Carb Coverage: # gm carb in meal = X units insulin	Correction Dose using ISF: bG - Target bG = X units insulin	Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have 1/2 unit marks; unless otherwise instructed by PCP/Endocrinologist. Round DOWN to nearest 0.1 unit for pumps, unless following pump recommendations or PCP/Endocrinologist orders.
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<p>For Pumps - Basal Rate in school: ____:____ AM/PM to ____:____ AM/PM ____ units/hr ____:____ AM/PM to ____:____ AM/PM ____ units/hr ____:____ AM/PM to ____:____ AM/PM ____ units/hr</p> <p><input type="checkbox"/> Student on FDA approved hybrid closed loop pump-basal rate variable per pump. <input type="checkbox"/> Suspend/disconnect pump for gym <input type="checkbox"/> Suspend pump for hypoglycemia not responding to treatment for ____ min.</p>	<p>Additional Pump Instructions:</p> <p><input type="checkbox"/> Follow pump recommendations for bolus dose (if not using pump recommendations, will round down to nearest 0.1 unit) <input type="checkbox"/> For bG > ____ mg/dl that has not decreased in ____ hours after correction, consider pump failure and notify parents. <input type="checkbox"/> For suspected pump failure: SUSPEND pump, give insulin by syringe or pen, and notify parents. <input type="checkbox"/> For pump failure. only give correction dose if > ____ hrs since last insulin</p>
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DIABETES MEDICATION ADMINISTRATION FORM [PART B]

Provider Medication Order Form – Office of School Health – School Year **2020-2021**

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CONTINUOUS GLUCOSE MONITORING (CGM) ORDERS [Please see 'Provider Guidelines for DMAF Completion']

Use CGM readings - For CGM's used to replace finger stick bG readings, only devices FDA approved for use and age may be used within the limits of the manufacturer's protocol. (sG = sensor glucose).

Name and Model of CGM: _____

For CGM used for insulin dosing: finger stick bG will be done when: the symptoms don't match the CGM readings; if there is some reason to doubt the sensor (i.e. for readings <70 mg/dl or sensor does not show both arrows and numbers)

CGM to be used for insulin dosing and monitoring - **must be FDA approved for use and age**

sG Monitoring Specify times to check sensor reading Breakfast Lunch Snack Gym PRN [if none checked, will use bG monitoring times]

For sG <70mg/dl check bG and follow orders on DMAF, unless otherwise ordered below.

Use CGM grid below OR See attached CGM instruction

CGM reading	Arrows	Action	<input type="checkbox"/> use < 80 mg/dl instead of < 70 mg/dl for grid action plan
sG < 60 mg/dl	Any arrows	Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.	
sG 60-70 mg/dl	and ↓, ↓↓, ↘ or →	Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.	
sG 60-70 mg/dl	and ↑, ↑↑, or ↗	If symptomatic, treat hypoglycemia per bG hypoglycemia plan; if not symptomatic, recheck in 15-20 minutes. If still <70 mg/dl check bG.	
sG >70 mg/dl	Any arrows	Follow bG DMAF orders for insulin dosing	
sG ≤ 120 mg/dl pre-gym or recess	and ↓, ↓↓	Give 15 gms uncovered carbs. If gym or recess is immediately after lunch, subtract 15 gms of carbs from lunch carb calculation.	
sG ≥ 250	Any arrows	Follow bG DMAF orders for treatment and insulin dosing	

For student using CGM, wait 2 hours after meal before testing ketones with hyperglycemia.

PARENTAL INPUT INTO INSULIN DOSING

Parent(s)/Guardian(s) (give name), _____, may provide the nurse with information relevant to insulin dosing, including dosing recommendations. Taking the parent's input into account, the nurse will determine the insulin dose within the range ordered by the health care practitioner and in keeping with nursing judgment.

Please select **one** option below:

1. Nurse may adjust calculated dose up or down up to ___ units based on parental input and nursing judgment.

2. Nurse may adjust calculated dose up by ___% or down by ___% of the prescribed dose based on parental input and nursing judgment

MUST COMPLETE: Health care practitioner can be reached for urgent dosing orders at: (____) _____ - _____

If the parent requests a similar adjustment for > 2 days in a row, the nurse will contact the health care practitioner to see if the school orders need to be revised.

SLIDING SCALE

Do NOT overlap ranges (e.g. enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. Use pre-treatment bG to calculate insulin dose unless other orders.

<input type="checkbox"/> Lunch	bG	Units Insulin	<input type="checkbox"/> Other	bG	Units Insulin
<input type="checkbox"/> Snack	Zero -		Time	Zero -	
<input type="checkbox"/> Breakfast	-			-	
<input type="checkbox"/> Correction	-		<input type="checkbox"/> Snack	-	
Dose	-		<input type="checkbox"/> Breakfast	-	
	-		<input type="checkbox"/> Correction	-	
	-		Dose	-	
	-			-	

OPTIONAL ORDERS

Round insulin dosing to nearest whole unit: 0.51-1.50u rounds to 1.00u.

Round insulin dosing to nearest half unit: 0.26-0.75u rounds to 0.50 u (must have half unit syringe/pen).

Use sliding scale for correction AND at meals ADD: ___ units for lunch; ___ units for snack; ___ units for breakfast (sliding scale must be marked as correction dose only).

Long acting insulin given in school – Insulin Name: _____
Dose: ___ units Time _____ or Lunch

SNACK ORDERS

Student may carry and self-administer snack
Snack time of day: ___ AM / PM Pre-gym Snack
Type & amount of snack: _____

OTHER ORDERS:

HOME MEDICATIONS

Medication	Dose	Frequency	Time	Route
Insulin:				
Other:				

ADDITIONAL INFORMATION

Is the child using altered or non-FDA approved equipment? Yes or No [Please note that New York State Education laws prohibit nurses from managing non-FDA devices. Please provide pump-failure and/or back up orders on DMAF Part A Form.]

By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s).

Health Care Practitioner Name LAST	FIRST	Signature	Date ____/____/____
(Please print and check one: <input type="checkbox"/> MD, <input type="checkbox"/> DO, <input type="checkbox"/> NP, <input type="checkbox"/> PA)		Tel. (____) _____	Fax. (____) _____
Address		CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.	
NYS License # (Required)	E-mail		

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to the nurse giving my child's prescribed medicine, and the nurse/trained staff checking their blood sugar and treating their low blood sugar based on the directions and skill level determined by my child's health care practitioner. These actions may be performed on school grounds or during school trips.
2. I also consent to any equipment needed for my child's medicine being stored and used at school.
3. I understand that:
 - I must give the school nurse my child's medicine, snacks, equipment, and supplies and must replace such medicine, snacks, equipment and supplies as needed. OSH recommends the use of safety lancets and other safety needle devices and supplies to check my child's blood sugar levels and give insulin.
 - **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, 3) my child's health care practitioner'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 must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner'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 diabetes-related 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 a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
 - OSH and the Department of Education (DOE) are responsible for making sure that my child can safely test his or her blood sugar.
 - This form represents my consent and request for the diabetes services described on this form. 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 Student Accommodation Plan. This plan will be completed by the school.
 - For the purposes of providing care or treatment for 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.

OSH Parent Hotline for questions about the Diabetes Medication Administration Form (DMAF): 718-310-2496

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 them the medicine prescribed on this form in school. 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 will confirm my child's ability to carry and give them medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child Glucagon if prescribed by their health care provider if my child is temporarily unable to carry and take medicine. **This does not include nasal Glucagon as New York State does not endorse training non-licensed personnel to administer nasal Glucagon at this time.**

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

Student Last Name		First Name		MI	Date of birth ___ / ___ / _____	
School ATSDBN/Name				Borough		District
Print Parent/Guardian's Name			SIGN HERE			Parent/Guardian's Signature for Parts A & B
						Date Signed ___ / ___ / _____
Parent/Guardian's Email						
Parent/Guardian's Address						
Telephone Numbers: Daytime (____) _____ - _____ Home (____) _____ - _____ Cell Phone (____) _____ - _____						
Alternate Emergency Contact's Name			Relationship to Student		Contact Telephone Number (____) _____ - _____	

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For Office of School Health (OSH) Use Only

OSIS Number:

Received by: Name

Date ___/___/_____

Reviewed by: Name:

Date ___/___/_____

504 IEP Other

Referred to School 504 Coordinator: Yes No

Services provided by: Nurse/NP

OSH Public Health Advisor (for supervised students only)

School Based Health Center

Signature and Title (RN OR SMD):

Date School Notified & Form Sent to DOE Liaison ___ / ___ / _____

Revisions as per OSH contact with prescribing health care practitioner

Modified

Not Modified

Notes: