Severe Hypoglycemia
Glucagon and CALL 911
GluGone or Basargin Zegalog
1 mg SC or 1 mg IM may repeat in 15 min if needed

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN if bg is unknown. Turn onto left side to prevent aspiration.

Risk for Ketones or Diabetic Ketoacidosis (DKA)
Test ketones if bg > 500 mg/dl or if vomiting, or fever > 100.5 F
If small or trace give water; re-test ketones & bg in 2 hrs or
If ketones are moderate or large, give water; Call parent and Endocrinologist
If ketones and vomiting, unable to take PO or MD not available, CALL 911
Give insulin correction dose if > 2 hrs or

SKILL LEVEL
Blood Glucose (bg) Monitoring Skill Level
Insulin Administration Skill Level

Independent Student Self-carry / Self-administer (MUST Initial attestation) I attest that the independent student demonstrated the ability to self-administer the prescribed medication effectively during school, field trips and school sponsored events.

BLOOD GLUCOSE MONITORING [See Part B for CGM readings]
Hypoglycemia
Check all boxes needed. Must include at least one treatment plan.
For bg < ________ mg/dl give ________ gm rapid carbs at ________ Give insulin after ________ Breakfast ________ Lunch ________ Snack ________ Gym ________ PRN
Repeat bg testing in 15 or ________ min. If bg still < ________ mg/dl repeat carbs and retesting until bg > ________

For bg < ________ mg/dl give ________ gm rapid carbs at ________ Give insulin after ________ Breakfast ________ Lunch ________ Snack ________ Gym ________ PRN
15 gm rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz.

Mid-Range Glycemia
Insulin is given before food unless noted here

Insulin is given before food unless noted here
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 ________ 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.

INCOMPETENT PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS OHS DMAF REV 3/22

FORMS CANNOT BE COMPLETED BY A RESIDENT  HEALTH CARE PRACTITIONERS: COMPLETE ‘PART B’ AND SIGN
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 Monitoring
Specify times to check sensor reading
☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN [If none checked, will use bG monitoring times] For sG $<70$ mg/dl check bG and follow orders on DMAF, unless otherwise ordered below. Use CGM grid below OR See attached CGM instruction

<table>
<thead>
<tr>
<th>sG reading</th>
<th>Arrows</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>$&lt;60$ mg/dl</td>
<td>Any arrows</td>
<td>Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still $&lt;70$ mg/dl check bG.</td>
</tr>
<tr>
<td>$60-70$ mg/dl and ↓↑↓</td>
<td>or ↓</td>
<td>Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still $&lt;70$ mg/dl check bG.</td>
</tr>
<tr>
<td>$60-70$ mg/dl and ↑↓↑</td>
<td>or ↓</td>
<td>If symptomatic, treat hypoglycemia per bG hypoglycemia plan; if not symptomatic, recheck in 15-20 minutes. If still $&lt;70$ mg/dl check bG.</td>
</tr>
<tr>
<td>$&gt;70$ mg/dl</td>
<td>Any arrows</td>
<td>Follow bG DMAF orders for insulin dosing</td>
</tr>
<tr>
<td>$≤120$ mg/dl pre-gym or recess and ↓↓↓</td>
<td>or ↓↓</td>
<td>Give 15 gms uncovered carbs. If gym or recess is immediately after lunch, subtract 15 gms of carbs from lunch carb calculation.</td>
</tr>
<tr>
<td>$≥250$</td>
<td>Any arrows</td>
<td>Follow bG DMAF orders for treatment and insulin dosing</td>
</tr>
</tbody>
</table>

☐ 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), 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.

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

<table>
<thead>
<tr>
<th>Time</th>
<th>bG</th>
<th>Units Insulin</th>
<th>Other Time</th>
<th>bG</th>
<th>Units Insulin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lunch</td>
<td>Zero – _____</td>
<td>☐ Lunch</td>
<td>☐ Lunch</td>
<td>Zero – _____</td>
<td>☐ Lunch</td>
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<tr>
<td>Snack</td>
<td>_____ – _____</td>
<td>☐ Snack</td>
<td>☐ Snack</td>
<td>_____ – _____</td>
<td>☐ Snack</td>
</tr>
<tr>
<td>Breakfast</td>
<td>_____ – _____</td>
<td>☐ Breakfast</td>
<td>☐ Breakfast</td>
<td>_____ – _____</td>
<td>☐ Breakfast</td>
</tr>
<tr>
<td>Correction Dose</td>
<td>_____ – _____</td>
<td>☐ Correction Dose</td>
<td>☐ Correction Dose</td>
<td>_____ – _____</td>
<td>☐ Correction Dose</td>
</tr>
</tbody>
</table>

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 meals ADD: 

☐ Long-acting insulin given in school - Dose _____ units - Time _____ or ☐ Lunch

保险公司 may carry and self-administer snack, Snack time of day: _____ Type & amount of snack:

HOME MEDICATIONS
☐ None

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
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</table>

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
Last Name (Print): ____________________________ First Name (Print): ____________________________

Signature: ____________________________ Date: ____________

NYS License # (Required): ____________________________ Check one: MD ☐ DO ☐ NP ☐ PA

Address: ____________________________ Email address: ____________________________

Tel.: ____________________________ FAX: ____________________________ Cell Phone: ____________________________
نورض إرسال جميع استمارات إعطاء دواء مرض السكري (DMAF) باللغة على الرقم 3932-8945 أو 347-396-8945.

استمارة إعطاء دواء مرض السكري

لاستمارة للطلاب من المدرسة الابتدائية 2023-2022

الاستمارة المعدلة بعد يوم 1 توقع المعالجة للعام الدراسي الجديد.

لتحاول الدواء بشكل ذكي، قد تكون هذه الاستمارة متضمنة فقط.

أقرأ أو أوك ذكر أن طلبي قد نقلني تدريبيًا كاملاً يمكنك تناول الدواء بنفسه. أوافق على أن تقوم طلب وحلزون وتناول الدواء الموصوف في هذه الاستمارة بنفسه في المدرسة. إذا كنت طالبًا في مدرسة، فقد تغير هذا في نهاية العام الدراسي الجديد.

لا ت thépزمه. 

اذا، في الأصل، يجب أن تخبر المدرسة بصحة الطالب أو الأسرة السابقة، إذا كان الطالب **غير قادر مؤقتًا على حمل الدواء وتناوله**.

الطاقة الصحية، إذا كان طالبًا غير قادر مؤقتًا على حمل الدواء وتناوله.

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OSIS Number: ___________________   Received by - Name: ___________________ Date: ________________
☐ 504 ☐ IEP ☐ Other: ________________________
Reviewed by - Name: ___________________ Date: ________________
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:  ☐ Clarified  ☐ Modified
Notes:

FOR PRINT USE ONLY | Confidential Information should not be sent by email.

T&I 34186 Diabetes MAF 2022-23 (Arabic)