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 DMAPs to 347-396-8932/8945.

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

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

Severe Hypoglycemia
Administer Glucagon and call 911
Glucagon: [ ] 1 mg [ ] mg SC/IM
GVOKE: [ ] 1 mg [ ] mg SC/IM
Basqmi: [ ] 3 mg Intranasal

Give PRN unconscious, unresponsive, seizure, or inability to swallow even if BG is unknown. Turn on left side to prevent aspiration.

Risk for Ketones or Diabetic Ketoacidosis (DKA)

Test ketones if BG > ____ mg/dl, or if vomiting, or fever > 100.5°F.
Test ketones if BG > ___ mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5°F
If small or trace give water: re-test ketones & BG in 2 hrs or ___ hrs
If ketones are moderate or large, give water:
Call parent and Endocrinologist: ☐ NO GYM
If ketones and vomiting, unable to take PO and MD not available, CALL 911

Give insulin correction dose if > 2 hrs or ___ hours since last insulin.

SKILL LEVEL

Blood Glucose (BG) Monitoring Skill Level
☐ Nurse / adult must check BG.
☐ Student to check BG with adult supervision.
☐ Student may check BG without supervision.

Insulin Administration Skill Level
☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised student: student self-administers, under adult supervision

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 for school, field trips, and school-sponsored events

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
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 snack.
Insulin is given before food unless noted here: Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack
Mid-range Glicemia: Insulin is given before food unless noted here: Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack
For BG > _____ mg/dl Gym, ☐ For BG > _____ mg/dl PRN: treat hypoglycemia then snack.

For BG > _____ mg/dl Gym, ☐ For BG > _____ mg/dl PRN: treat hypoglycemia then snack.

Check BG or Sensor Glucose (sG) before dismissal
☐ For sG or BG values < _____ mg/dl for hypoglycemia if needed, and give ___ gm snack if needed, do not send on bus/mass transit, parent to pick up from school.

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS.

INSULIN ORDERS

Name of Insulin*: ☐ Humalog/Ademalog ☐ Lantus/NovoLog
May substitute Novolog with Humalog/Ademalog
No Insulin in School
No Insulin at Snack

Insulin Calculation Method:
☐ Carb coverage ONLY at: ☐ Breakfast ☐ Lunch ☐ Snack
☐ Correction dose ONLY at: ☐ Breakfast ☐ Lunch ☐ Snack
☐ Carb coverage plus correction dose when BG > Target AND at least 2 hrs or ___ hrs since last insulin at
☐ Breakfast ☐ Lunch ☐ Snack
Correction dose calculated using: ☐ ISF ☐ Sliding Scale
Fixed Dose (see Other Orders)
Sliding Scale (See Part B)
If gym/recess is immediately following lunch, subtract ___ gm carbs from lunch carb calculation.

Insulin Calculation Directions: (give number, not range)
Target BG = _____ mg/dl
Insulin to Carb Ratio (I:C):
Bkfast OR time: _____ to _____
1 unit decreases BG by ___ mg/dl
(time: _____ to _____)
1 unit decreases BG by ___ mg/dl
(time: _____ to _____)
Lunch OR time: _____ to _____
1 unit per ___ gms carbs
Snack OR time: _____ to _____
1 unit per ___ gms carbs

Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen does not have ½ unit marks, unless otherwise instructed by PCBP/Endocrinologist. Round DOWN to nearest 0.1 unit for pumps, unless following pump recommendations or PCBP/Endocrinologist orders.

Carb Coverage:
# gm carb in meal = ___ units insulin
# gm carb in 1/C

Correction Dose using ISF:
bg – Target bg = ___ units insulin
ISF

Additional Pump Instructions:
☐ Follow pump recommendations for bolus dose (if not using pump recommendations, will round down to nearest 0.1 unit)
☐ For BG < _____ mg/dl that has not decreased in ___ hours after correction, consider pump failure and notify parents.
☐ For suspected pump failure: SUSPEND pump, give insulin by syringe or pen, and notify parents.
☐ For pump failure, only give correction dose if > ___ hrs since last insulin

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
☐ AM/PM to: AM/PM ___ units/hr
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☐ AM/PM to: AM/PM ___ units/hr
☐ AM/PM to: AM/PM ___ units/hr
☐ Student on FDA approved hybrid closed loop pump-basal rate variable per pump.
☐ Suspend/disconnect pump for gym
☐ Suspend pump for hypoglycemia not responding to treatment for ___ min.

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. FORMS CANNOT BE COMPLETED BY A RESIDENT

HEALTH CARE PRACTITIONERS: COMPLETE ‘PART B’ AND SIGN ➔
DIABETES MEDICATION ADMINISTRATION FORM [PART B]
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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:

☐ 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

Name and Model of CGM:______________________________

Address

☐ Health Care Practitioner Name

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

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.

<table>
<thead>
<tr>
<th>Lunch</th>
<th>bG Units</th>
<th>Insulin</th>
<th>Other bG Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Breakfast</td>
<td>__ ______</td>
<td>______</td>
<td>__ ______</td>
</tr>
<tr>
<td>☐ Snack</td>
<td>__ ______</td>
<td>______</td>
<td>__ ______</td>
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</tbody>
</table>

Dose: __ ______ 

Snack time of day: ___ AM / PM ☐ Pre-gym Snack

Type & amount of snack:

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

OTHER ORDERS:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Time</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin:</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Other:</td>
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ADDITIONAL INFORMATION

Is the child using altered or non-FDA approved devices? ☐ 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: __________________________

(Please print and check one: ☐ MD, ☐ DO, ☐ NP, ☐ PA)

Address

☐ Tel. (____) ____ / ____ / ____ ☐ Fax. (____) ____ / ____

NYS License # (Required): __________________________

E-mail

CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.
**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 their 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.

<table>
<thead>
<tr>
<th>Student Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of birth __ / __ / ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>School ATSDBN/Name</td>
<td>Borough</td>
<td>District</td>
<td></td>
</tr>
<tr>
<td>Print Parent/Guardian’s Name</td>
<td>Parent/Guardian’s Signature for Parts A &amp; B</td>
<td>Date Signed __ / __ / ______</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian’s Email</td>
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<td></td>
<td></td>
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<tr>
<td>Parent/Guardian’s Address</td>
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<td></td>
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</tr>
<tr>
<td>Telephone Numbers:</td>
<td>Daytime (______) ______ - ______</td>
<td>Home (______) ______ - ______</td>
<td>Cell Phone (______) ______ - ______</td>
</tr>
</tbody>
</table>

| Alternate Emergency Contact’s Name | Relationship to Student | Contact Telephone Number (______) ______ - ______ |
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For Office of School Health (OSH) Use Only

<table>
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<tr>
<th>OSIS Number:</th>
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<tr>
<th>Received by: Name</th>
<th>Date <em><strong>/</strong></em>/___</th>
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<tbody>
<tr>
<td>Reviewed by: Name:</td>
<td>Date <em><strong>/</strong></em>/___</td>
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- 504 □ IEP □ Other
- Reflected to School 504 Coordinator: □ Yes □ No

| Services provided by: | □ Nurse/NP | □ OSH Public Health Advisor (for supervised students only) | □ School Based Health Center |

<table>
<thead>
<tr>
<th>Signature and Title (RN OR SMD):</th>
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<tr>
<th>Date School Notified &amp; Form Sent to DOE Liaison</th>
<th>___ / ___ / ___</th>
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| Revisions as per OSH contact with prescribing health care practitioner | □ Modified | □ Not Modified |

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<tr>
<th>Notes:</th>
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