DIABETES MEDICATION ADMINISTRATION FORM <u>ADDENDUM</u>
Provider Medication Order Form – Office of School Health – School Year **2018-2019**

Student Last Name	First Name	MI	**Date of birth** __ __ / __ __ / __ __ __ __	☐ Male ☐ Female	**OSIS #** – – – – – – – – –
School (include name, number, address and borough)			**DOE District**	**Grade**	**Class**

CONTINUOUS GLUCOSE MONITORING (CGM) ORDERS

For CGM's used to replace finger stick bG readings, only FDA approved devices may be used. For any CGMs:
1) If the reading is not consistent with symptoms, a bG reading will be done.
2) School nurses may not monitor CGM values remotely. Nurses and school staff may not monitor a CGM on a personal device. If a student has an assigned para-professional, the para may monitor the CGM via the device's receiver.
3) Families are responsible for calibrating the CGM and changing the sensor in accordance with the device's manufacturer's protocols.
4) Families are responsible for notifying the school nurse if a medication containing acetaminophen was given before school that day.

Check one:
☐ CGM to be used for monitoring ONLY
☐ FDA approved CGM to be used to replace finger stick bG readings, within the limits of the manufacturer's protocols.
    Name and Model of CGM: _____.

For Dexcom 5 - finger stick bG will be done when:
1. The symptoms don't match the CGM readings
2. The student has taken acetaminophen (Tylenol® in the past 8 hours)
3. There is some reason to doubt the sensor (e.g. sensor doesn't have both arrow and number)
4. Readings < 70 mg/dl
If CGM needs calibration, test bG.

This section is only for CGM used for dosing

☐ For sG <___mg/dl and any↓ or ↓↓ or ↘, check bG.

☐ For sG <___mg/dl and any ↓, ↓↓, ↘ or →: Give _ oz Juice OR __ gm carbs OR __glucose tab/glucose gel.

    ☐ After treatment, retest sG in 15 min., if sG still < __ mg/dl repeat carbs and retesting until sG > ___.

☐ For sG <___mg/dl and ↑ , ↑↑, or ↗ Give _ oz Juice OR __ gm carbs OR __ glucose tab/glucose gel.
    ☐ After treatment, retest bG in 15 min., if bG still < __ mg/dl repeat carbs and retesting until bG > ___.

☐ For sG >___mg/dl and ↓↓: ☐Give **OR** ☐ DON'T Give - correction dose per DMAF, recheck sG in __ hr. Other adjustment:

☐ For sG >___mg/dl and ↓ or ↘ : ☐Give **OR** ☐ DON'T Give - correction dose per DMAF, recheck sG in __ hr. Other adjustment:

☐ For sG >___mg/dl and →: ☐Give **OR** ☐ DON'T Give - correction dose per DMAF, recheck sG in __ hr. Other adjustment:

☐ For sG >___mg/dl and ↑ or ↗: ☐Give **OR** ☐ DON'T Give - correction dose per DMAF, recheck sG in __ hr. Other adjustment:

☐ For sG >___mg/dl and ↑↑: ☐Give **OR** ☐ DON'T Give - correction dose per DMAF, recheck sG in __ hr. Other adjustment:

☐ For sG <___mg/dl and ↓ or ↓↓: Give snack of ___ gm carbs.

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

PARENTAL INPUT INTO INSULIN DOSING

☐ My patient's Parent(s)/Guardian(s), _____, 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 <u>and</u> in keeping with nursing judgment.

Please select <u>one</u> option below:

1. ☐ Nurse may adjust calculated dose up or down up to __ units based on parental input and nursing judgement.

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

If parental recommendation is significantly different than the dose determined by the nurse, the nurse should contact the ordering health care practitioner for a one time order. If the health care practitioner cannot be immediately reached the nurse will give the lower dose that falls within the health care practitioner's ordered range.

<u>**MUST COMPLETE**</u>: **Health care practitioner can be reached for urgent dosing orders at: (_____) _____ - _____**
If the parent requests a similar adjustment for more than two days in a row the nurse will contact the health care practitioner to see if the in school orders need to be revised.

BREAKFAST ORDERS

The school nurse may not always be on site when breakfast is served. It is the parent's responsibility to ensure a back-up plan is in place to provide insulin coverage if/when the school nurse is not on site to give insulin prior to breakfast.

If the nurse is not present, please explain your plan to give insulin:
(e.g. parent will give insulin; OR grandmother will come give insulin after breakfast, etc.)
_____
_____

PROVIDER INITIALS	☐ Student may self-administer without supervision if nurse not available at breakfast. I attest that the student demonstrates the ability to self-administer the prescribed medication effectively for school, field trips & school sponsored events. *[Parent must sign and date consent on DMAF form]*

Health Care Practitioner Name LAST	FIRST	Signature	
			Date __ __ / __ __ / __ __ __ __
Address		Tel. (__ __ __) __ __ __ - __ __ __ __	Fax. (__ __ __) __ __ __ - __ __ __ __
NYS License # **(Required)**	NPI # __ __ __ __ __ __ __ __ __ __	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**	

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS   FORMS CANNOT BE COMPLETED BY A RESIDENT   Rev 3/18