Attach student photo here

☐ Addendum Attached

DIABETES MEDICATION ADMINISTRATION FORM

Provider Medication Order Form – Office of School Health – School Year **2018-2019**

DUE: JULY 15th. Forms submitted after July 15th 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** | ☐ Male ☐ Female | **OSIS #**

School (include name, number, address and borough) | **DOE District** | **Grade** | **Class**

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other Diagnosis: Recent A1C: Date / / Result . %

HEALTH CARE PRACTITIONERS COMPLETE BELOW

NOTE: Orders received on this form will be processed for the September 2018 through August 2019 school year unless noted: ☐ Current Year '17-'18 **ONLY**

Emergency orders

Severe Hypoglycemia
Administer **Glucagon** and **call 911**
☐ 1 mg SC/IM
☐ ___mg SC/IM
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 >___mg/dl, or if vomiting, or fever > 100.5F
☐ Call endocrinologist if bG = "Hi"
➢ If small or trace give water; re-test ketones & bG in ___ hrs
➢ If initial or retest ketones are moderate or large, give water
☐ Call parent and Endocrinologist ☐ **NO GYM**
If vomiting, unable to take PO and MD not available, **CALL 911**
☐ Give insulin correction dose if >__ hours since last insulin.

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:*
NOTE: Trip nurse not required for supervised or independent students.

PROVIDER INITIALS ____ I attest student demonstrated the ability to self-administer the prescribed medication effectively for school, field trips, & school/sponsored events

bG Monitoring: Test bG at ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

☐ Use CGM readings but not for insulin dosing (**see DMAF Addendum form**)
☐ Use FDA approved CGM readings for bG monitoring and insulin dosing. Test bG per CGM orders (**see DMAF Addendum form**)

Breakfast Orders: Complete DMAF Addendum for breakfast orders

Hypoglycemia:

Check all boxes needed. Must include at least one treatment plan. Use pre-treatment bG to calculate insulin dose unless otherwise prescribed.

☐ For bG < ______mg/dl give _____ gm rapid carbs or __ glucose tabs or ____ glucose gel or __ oz. juice 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 give _____ gm rapid carbs or __ glucose tabs or ____ glucose gel or __ oz. juice 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 give _____ gm rapid carbs or __ glucose tabs or ____ glucose gel or __ oz. juice 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.

☐ Give insulin after: ☐ breakfast ☐ lunch ☐ snack

Snack:
Student may carry and self-administer snack ☐ Yes ☐ No
Time of day: _____ AM _____ PM
Type, amount: ________________ ________________
☐ **NO INSULIN TO BE GIVEN AT SNACK TIME**

Mid-range Glycemia:

☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN ☐ Give snack before gym

Hyperglycemia:

☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack
☐ For bG > ___mg/DL or **and** mod/lg Ketones ☐ Pre-gym and/or ☐ PRN – **NO GYM**
☐ For bG > ___mg/DL or ☐ Pre-gym and/or ☐ PRN, **NO GYM**
☐ For bG meter reading "High" use bG value of ___mg/DL. If not specified, nurse will use bG value of 500 mg/dL.

Insulin orders:
Insulin is given before meals unless otherwise noted
☐ No Insulin in School
☐ Insulin Name: _______________
Delivery method: ☐ Syringe ☐ Pen
☐ Pump (Brand) _______________
☐ **Parent may have input into insulin dosing. See DMAF Addendum form.**

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 ___ hr. since last insulin at ☐ Breakfast ☐ Lunch ☐ Snack
Correction dose calculated using:
☐ ISF
☐ Sliding Scale ☐ Fixed Dose (see Other Orders)

Insulin Calculation Directions: *(give number, not range)*
Target bG = ___ mg/dl
Insulin Sensitivity Factor (ISF):
1 unit decreases bG by ___ mg/dl (time:_____ to _____)
1 unit decreases bG by ___ mg/dl: (time:_____ to _____)
Insulin to Carb Ratio (I:C):
Lunch: 1 unit per ___ gms carbs
Snack: 1 unit per ___ gms carbs
Breakfast: 1 unit per ___ gms carbs

Carb Coverage:
$\frac{\text{\# gm carb in meal}}{\text{\# gm carb in I:C}} = X$ units insulin

Correction Dose using ISF:
$\frac{\text{bG – Target bG}}{\text{ISF}} = X$ units insulin

Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have ½ 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.

For Pumps - Basal Rate in school:
__:___ units/hr __:___ AM/PM to __:__ AM/PM
__:___ units/hr __:___ AM/PM to __:__ AM/PM
__:___ units/hr __:___ AM/PM to __:__ AM/PM
Basal rate for Gym
__.__ units/hr
___.__ % for __ hrs
☐ 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.

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

Sliding Scale: *Do NOT overlap ranges (e.g. enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given.*

	bG	Units Insulin
☐ Breakfast		
☐ Lunch	Zero -___	_____
☐ Snack	___-___	_____
☐ Correction Dose	___-___	_____
	___-___	_____
	___-___	_____
	___-___	_____

	bG	Units Insulin
☐ Other Time	Zero -___	_____
_________	___-___	_____
☐ Breakfast	___-___	_____
☐ Snack	___-___	_____
☐ Correction Dose	___-___	_____
	___-___	_____

Home Medication

Medication	Dose	Frequency	Time	Route
Insulin:				
Other:				

Other Orders: (attach additional page, signed and dated, if needed)

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.**

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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 my child's school checking my child's blood sugar, and treating my child's low blood sugar based on my child's health care practitioner's directions. The school may perform these actions 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, and equipment. I will try to give the school 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 get another medicine for my child to use when he or she is not in school or is on a school trip.**
     - 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.
   - The Office of School Health (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), OSH may provide health services to my child. These services may include 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).
   - If this medication order expires, and my child's health care practitioner does not write a new MAF, an OSH health care practitioner may fill out a new diabetes MAF for my child. **OSH will not need my signature to write future diabetes MAFs.**
   - OSH and the Department of Education (DOE) are responsible for making sure that my child can safely test his or her blood sugar in the medical room and any school location.
   - 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.
   - 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.
   - If the school nurse is unavailable, I may be notified to come to school to give my child medicine.

FOR SELF-ADMINISTRATION OF MEDICINE:

- 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. 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 him or herself 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 medicine if my child is temporarily unable to carry and give him or herself medicine.

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

Print Parent/Guardian's Name	**SIGN HERE**	**Parent/Guardian's Signature**

Date Signed __ __ / __ __ / __ __ __ __	**Parent/Guardian's Email**	**Parent/Guardian's Address**

Telephone Numbers: **Daytime** (__ __ __) __ __ __ - __ __ __ __ **Home** (__ __ __) __ __ __ - __ __ __ __ **Cell Phone** (__ __ __) __ __ __ - __ __ __ __

Alternate Emergency Contact's Name	**Contact Telephone Number** (__ __ __) __ __ __ - __ __ __ __

For Office of School Health Use Only

OSIS Number: ☐ **504** ☐ **IEP** ☐ **Other**

Received by: Name Date___/___/_____	**Reviewed by**: Name Date_____/___/_____

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor *(For supervised students only)* ☐ School Based Health Center

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

Revisions per OSH after consultation with prescribing health care practitioner ☐ Modified ☐ Not Modified

*Confidential Information should not be sent by email