學生照片
附此

糖尿病藥物施用表[A部分]

提供者醫療手續執行表 - 學校健康辦公室 - **2020-2021**學年

截止日期：6月1日。6月1日之後遞交的表格可能會延遲受理新學年服務的申請。請將所有的糖尿病藥物施用表（DMAF）傳真到347-396-8932/8945。

學生 姓氏 名字 中間名首字母	**出生日期**	☐ 男 ☐ 女	**學生身份號碼#**
學校（包括ATSDBN/名稱、地址和行政區）	**教育局學區**	**年級**	**班級**

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

Severe Hypoglycemia
Administer **Glucagon** and **call 911**
Glucagon: ☐ 1 mg ☐ ___ mg SC/IM
GVOKE: ☐ 1 mg ☐ ___ mg SC/IM
Baqsimi: ☐ 3 mg Intranasal

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
OR
☐ Test ketones if bG >__mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5F
- 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, & school/sponsored events
PROVIDER INITIALS

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 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.

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

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.

☐ T2DM - no bG monitoring or insulin in school

15 gm rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz.

Snack orders on DMAF Part B

INSULIN ORDERS

Name of Insulin*:
_____
* May substitute Novolog with Humalog/Admelog
☐ No Insulin in School
☐ No Insulin at Snack ☐ ☐

Delivery Method:
☐ Syringe/Pen
☐ Pump *(Brand)*:
_____
☐ Smart Pen – use pen suggestions

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 **or** ☐ 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 Sensitivity Factor (ISF):
1 unit decreases bG by ___ mg/dl
(time:_____ to _____)
1 unit decreases bG by ___ mg/dl:
(time:_____ to _____)

If only one ISF, time will be 8am to 4pm if not specified.

Insulin to Carb Ratio (I:C):

Bkfast **OR** time:____to ____
1 unit per ___ gms carbs

Snack **OR** time:____to ____
1 unit per ___gms carbs

Lunch **OR** time:____to ____
1 unit per ___ gms carbs

Lunch followed by gym
1 unit per ___ gms carbs

Carb Coverage:	**Correction Dose using ISF:**	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.
# gm carb in meal / # gm carb in I:C = X units insulin	bG – Target bG / ISF = X units 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
☐ 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

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 4/20

HEALTH CARE PRACTITIONERS: COMPLETE 'PART B' AND SIGN ➔

Student Name (Last, First): _____ **OSIS Number:**_____

DIABETES MEDICATION ADMINISTRATION FORM [PART B]

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.

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 ☐ 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.

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

☐Other Time	bG Zero -	Units Insulin
_____	___-___	_____
☐Snack	___-___	_____
☐ Breakfast	___-___	_____
☐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 (**Please print and check one:** ☐ MD, ☐ DO, ☐ NP, ☐ PA)	Signature	Date ___ ___ / ___ ___ / ___ ___ ___ ___
Address	Tel. (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	Fax. (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
NYS License # **(Required)** E-mail	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**	

請交還給學校護士。6 月 1 日之後遞交的表格可能延遲受理新學年服務的申請

家長/監護人填寫以下內容

我在下面簽名，表示我同意如下：

1. 我同意，學校保存我子女的醫藥並根據我子女的保健專業人員的說明給藥。我也同意，我子女的醫藥所需的任何器材都在學校裏儲存和使用。
2. 我理解：
   - 我必須把我子女的醫藥和器材交給學校護士。我將儘量給學校有伸縮針頭的腎上腺素注射器（Iepinephrine pens with retractable needles）。
   - **我所給予學校的所有處方和非處方藥物都必須是新的、未曾打開過並裝在其原封瓶子或盒子裏。將給學校提供供我子女在上學日內使用的當前、未過期的醫藥用品。**
     - 處方藥物必須在其盒子或瓶子上有原裝藥房標籤。標籤必須包括：1) 我子女的姓名， 2) 藥房名稱和電話號碼， 3) 我子女的保健專業人員姓名， 4) 日期， 5) 重配次數， 6) 藥物名稱， 7) 劑量， 8) 何時用藥， 9) 如何用藥 以及 10) 任何其他說明。
   - 我謹此證明/確認，我已諮詢我子女的保健專業人員，並且我同意學校健康辦公室在萬一我子女沒有哮喘藥物或腎上腺素藥物之際可以給我子女施用儲存的藥物。
   - 如果我子女的藥物發生任何變化或者保健專業人員的說明有任何變化，我必須**立即**告知學校護士。
   - 涉及到給我子女提供上述健康服務的學校健康辦公室（OSH）及其代理人員依賴於本表資訊的精確度。
   - 我在這一「藥物施用表」（Medication Administration Form，簡稱 MAF）上簽名，表示授權學校健康辦公室（Office of School Health，簡稱 OSH）為我子女提供健康服務。這些服務可以包括（但不限於）由一名 OSH 辦公室保健專業人員或護士所執行的一次臨床評估或一次體檢。
   - 這份 MAF 表的醫療執行手續的過期時間是我子女的學年結束（這可能包括暑期班）或者當我交給學校護士一份新的 MAF（取兩者中較早的那個時間）。當這份醫療手續執行要求過期時,我將交給我子女的學校護士一份新的由我子女的保健專業人員出具的 MAF。OSH 在以後出具 MAF 時將不需要我的簽名。
   - 這份表格代表我對本表所說明的過敏服務的同意和要求。這並非 OSH 提供所要求的服務的協議。如果 OSH 決定提供這些服務，我子女可能還需要一份「學生特別照顧計劃」（Student Accommodation Plan）。這份計劃將由學校填寫。
   - 爲著給我子女提供護理或治療的目的，OSH 可以獲取該辦公室認爲有關我子女的醫療狀況、藥物和治療而需要的任何其他資訊。OSH 可以從任何為我子女提供健康服務的保健專業人員、護士或藥劑師那裏獲取該資訊。

自己用藥（僅適用於能自己獨立用藥的學生）：

- 我證明/確認，我子女已得到完全的訓練並能夠自行用藥。我同意，我子女在學校裏自己攜帶、儲存本表所開具的藥物並將自己用藥。我負責根據上述說明把瓶子或盒子裏的藥物交給我子女。我也負責監督我子女在學校裏的藥物使用情況及其對這一藥物使用所產生的任何結果。學校護士將確認我子女擁有攜帶和自行用藥的能力。我也同意交給學校「備用」藥物（裝在清楚地標示的盒子或瓶子裏）。
- 我同意，如果我子女臨時不能攜帶或自行用藥，學校護士或經過訓練的學校員工可以給我子女施用腎上腺素。

註：如果您決定使用儲存的藥物，則您必須在您子女參加學校外出參觀的日子以及/或者課後計劃時讓子女帶上 epinephrine、哮喘吸入器以及其他獲准的自我施用藥物，以備您子女使用。儲存的藥物只是由 OSH 員工在學校使用。

學生 姓 名 中名首字母	出生日期__ __ / __ __ / __ __ __ __	學校
學校 ATSDBN/名稱	行政區	學區
家長/監護人姓名（清楚書寫） **在此簽名**	**家長/監護人簽名**	**簽名日期** __ __ / __ __ / __ __ __ __
家長/監護人電子郵箱	**家長/監護人地址**	

電話號碼 日間 (__ __ __) __ __ __ - __ __ __ __ **住宅** (__ __ __) __ __ __ - __ __ __ __ **手機*** (__ __ __) __ __ __ - __ __ __ __

其他緊急聯絡人姓名	**與學生的關係**	**聯絡電話**(__ __ __) __ __ __ - __ __ __ __

For Office of School Health (OSH) Use Only（僅供工作人員填寫）

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

*請不要使用電子郵件發送保密資訊

只供印刷用

DIABETES MEDICATION ADMINISTRATION FORM

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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: