Kole foto elèv la la a

FÒM POU BAY MEDIKAMAN KONT DYABÈT [PATI A]

Fòm kòmand medikaman pou founisè – Biwo sante lekòl – Ane lekòl 2020-2021

DELÈ: 1ye jen Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la. Tanpri fakse tout DMAF nan 347-396-8932/8945.

Siyati elèv la	Non elèv la	Inisyal	**Dat nesans**	☐ Gason ☐ Fi	**# OSIS**
Lekòl (mete ATSDBN non, nimewo, adrès ak borough)			**Distri DOE**	**Klas**	**Nivo Klas**

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.**	

DEMAND POU TRETMAN DOKTÈ REKÒMANDE (SE PA POU BAY MEDIKAMAN)

Fòm demand tretman pou founisè | Biwo sante lekòl | Ane lekòl **2020-2021**

Tanpri voye l tounen ba enfimyè lekòl la. Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la.

PARAN/RESPONSAB RANPLI PATI PI BA A

LÈ M SIYEN PI BA, MWEN DAKÒ AVÈK BAGAY SA YO:

1. Mwen dakò pou yo konsève medikaman pitit mwen ak ba li yo nan lekòl la dapre eksplikasyon doktè pitit mwen an bay. Mwen dakò tou pou yo konsève nenpòt ekipman yo bezwen pou yo ka konsève medikaman pitit mwen an ak itilize l nan lekòl la.
2. Mwen konprann ke:
   - Mwen dwe bay enfimyè lekòl la medikaman ak ekipman pitit mwen an. M ap eseye bay lekòl la epinephrine pens ansanm ak egwi retraktab yo.
   - **Tout medikaman ak preskripsyon ak tout medikaman "ki vann san preksripsyon(over-the-counter)" fèt pou nèf, kachte nan bwat oswa boutèt orijinal la. M ap bay lekòl la medikaman ki resan, ki pa ekspire pou pitit mwen itilize pandan jounen lekòl la..**
     - Medikaman ki vann ak preskripsyon yo fèt pou gen etikèt orijinal famasi a sou bwat la oswa sou boutèy la. Etikèt la dwe gen ladan: 1) non pitit mwen an, 2) non ak nimewo telefòn famasi a, 3) non doktè pitit mwen an, 4) dat, 5) kantite rechaj(refills), 6) non medikaman an, 7) dozaj, 8) lè pou li pran l, 9)kòman pou li pran medikaman an ak 10) nenpòt lòt eksplikasyon.
   - Mwen sètifye/konfime mwen pale avèk doktè pitit mwen an epi mwen bay konsantman m pou OSH ba pitit mwen an medikaman ki disponib nan lekòl la nan ka kote medikaman kont opresyon medikaman epinephrine pa ta disponib.
   - Mwen dwe di enfimyè lekòl la **imedyatman** nenpòt chanjman ki genyen nan medikaman pitit mwen an oswa nan eksplikasyon doktè k ap trete l.
   - OSH ak ajan li ki patisipe nan ofri pitit mwen an sèvis sante ki pi wo yo konte sou presizyon ki nan enfòmasyon ki sou fòm sa a.
   - Lè m siyen fòm pou bay medikaman sa a (medication administration form, MAF) sa a, mwen otorize Biwo sante lekòl (Office of School Health, OSH) pou bay pitit mwen an sèvis sante. Sèvis sa yo ka genyen ladan pami lòt, yon evalyasyon klinik oswa yon konsiltasyon medikal yon doktè oswa yon enfimyè OSH fè.
   - Lòd pou bay medikaman ki sou fòm MAF sa a ekspire nan fen ane lekòl pitit mwen an, ki ka gen ladan tou sesyon ete, oswa lè mwen bay enfimyè lekòl la yon nouvo fòm MAF(kèlkeswa sa ki rive avan an). Lè preskripsyon medikaman sa a ekspire, m ap bay enfimyè lekòl pitit mwen an yon nouvo fòm MAF ke doktè pitit mwen an ap ekri. OSH will not need my signature for future MAFs.
   - Fòm sa a reprezante konsantman m pou sèvis alèji yo dekri nan fòm sa a. se pa yon akò OSH genyen pou li bay sèvis ou mande a. Si OSH deside bay sèvis sa yo, pitit mwen an bezwen tou yon Plan akomodasyon pou elèv. Se lekòl la k ap ranpli plan sa a.
   - Nan objektif pou bay pitit mwen an swen oswa tretman, OSH ka gen nenpòt lòt enfòmasyon yo panse ki nesesè sou pwoblèm medikal pitit mwen an, medikaman l ap pran oswa tertman l suiv. OSH ka pran enfòmasyon sa a nan men nenpòt doktè, enfimyè oswa famasyen ki bay pitit mwen an sèvis.

POU ELÈV KI KA PRAN MEDIKAMN POUKONT YO (ELÈV KI ENDEPANDAN SÈLMAN)

- Mwen sètifye/konfime pitit mwen an resevwa bon jan trening epi li kapab pran medikaman poukont li. Mwen dakò pou pitit mwen an pote, konsève ak pran poukontli medikaman yo preskri nan fòm sa a nan lekòl la. Mwen gen responsablite pou bay pitit mwen an medikaman sa a nan boutèy oswa nan bwat yo jan yo dekri sa pi wo a. Mwen gen responsablite pou m sipèvize itilizasyon medikaman pitit mwen an ak pou tout konsekans ki genyen nan itilizasyon medikaman pitit mwen an pran nan lekòl la. Enfimyè lekòl la pral konfime kapasite pitit mwen an pou l pote ak pran medikaman yo poukont li. Mwen dakò tou pou m bay lekòl la medikaman "an rezèv" nan yon bwat oswa boutèy ki gen etikèt byen klè sou li.
- Mwen dakò pou enfimyè lekòl la oswa manm estaf ki resevwa trening bay pitit mwen an epinephrine si li pa kapab pote ak pran yo poukont li pou yon ti tan.

SONJE: <u>Si ou chwazi pou itilize medikaman ki nan depo lekòl la, ou dwe voye pitit ou a avèk epinephrine, ponp opresyon ak lòt medikaman ki apwouve li gen pou pran poukont li nan pwomnad lekòl la</u> ak/oswa nan pwogram aprelekòl pou li ka genyen li disponib. Medikaman ki nan depo yo se sèlman estaf OSH ki nan lekòl la ki pou itilize yo.

Siyati elèv la	Non elèv la	Inisyal	Dat nesans elèv la __ __ / __ __ / __ __ __ __	Lekòl
Non/ATSDBN lekòl la			Borough	Distri
Non Paran/Responsab (enprime)		**SIYEN LA**	**Siyati paran/responsab**	**Dat siyati a** __ __ / __ __ / __ __ __ __
Imèl paran/responsab la			**Adrès Paran/Responsab**	

Nimewo telefòn: **Lajounen** (__ __ __) __ __ __ - __ ___ **Lakay** (__ __ __) __ __ __ - __ __ __ __ **Selilè*** (__ __ __) __ __ __ - __ __ __ __

Non lòt moun pou kontakte nan ka ijans **Lyen avèk elèv la**

Nimewo Telefòn lòt moun pou nou kontakte a (__ __ __) __ __ __ - __ __ __ __

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** __ __ / __ __ / __ __ __ __

POU DOKINAN KI ENPRIME SÈLMAN Ou pa dwe voye enfòmasyon konfidansyèl pa imèl.

DIABETES MEDICATION ADMINISTRATION FORM

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.

For Office of School Health (OSH) Use Only *(Para uso exclusivo de la OSH)*

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: