NYC Health | Office of School Health

糖尿病藥物施用表[A部分]

提供者醫療手續執行表 | **2023-2024**學年

截止日期：6月1日。6月1日之後遞交的表格可能會對新學年的申請程序造成延誤。 **請將所有的糖尿病藥物使用表(DMAF) 傳真到347-396-8932/8945。**

學生姓氏：_____ 名字：_____ 出生日期: _____

學生身份（OSIS）號碼：_____ 教育局學區：_____ 年級：_____班級：_____ 性別： ☐ 男 ☐ 女

學校（包括名稱、號碼、地址和行政區）：_____

學生姓氏：_____ 名字：_____ OSIS號碼：_____

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 implemented when submitted and approved. If you wish to delay orders for September 2023 please check here ☐

EMERGENCY ORDERS

Severe Hypoglycemia
Administer Glucagon and CALL 911

Glucagon	GVOKE	Baqsimi	Zegalogue
☐ 1 mg ☐ _____mg SC/IM	☐ 1 mg ☐ _____mg SC/IM	☐ 3 mg Intranasal	☐ 0.6 mg SC May repeat in 15 min if needed

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration. If more than one option is chosen, school staff will use ONE form of available glucagon unless otherwise directed.

Risk for Ketones or Diabetic Ketoacidosis (DKA)

☐ Test ketones if bG > _____ mg/dl or if vomiting, or fever > 100.5 F
OR
☐ 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 rapid acting insulin.

SKILL LEVEL *(if not complete, will default to nurse-dependent)*

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 calculates and self-administers, under adult supervision

☐ **Independent Student Self carry / Self-administer** (*MUST initial attestation*). I attest that the independent student demonstrated ability to self-administer the prescribed medication (excluding glucagon) effectively during school, field trips and school sponsored events.

_____
Provider Initials

BLOOD GLUCOSE MONITORING [See Part B for CGM readings]

Specify times to test bG in school (must match times for treatment and/or insulin) ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

Hypoglycemia *Insulin is given before food unless noted here* ☐ Give insulin after ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give Snack before gym

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 min 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 min 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 treat hypoglycemia and then give snack ☐ Pre-gym ☐ PRN

☐ T2DM – no bG monitoring or insulin in school

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

Mid-Range Glycemia *Insulin is given before food unless noted here* ☐ Give insulin after ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give Snack before gym if bG <_____mg/dl

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

☐ For bG _____mg/dl pre-gym, NO GYM For bG meter reading "High" use bG of 500 or _____mg/dl

☐ For bG >_____mg/dl PRN, Give insulin correction dose if > 2 hrs or___hrs. since last rapid acting insulin

☐ **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.*

INSULIN ORDERS

Insulin Name

_____
**May substitute Novolog with Humalog/Admelog*

☐ No Insulin in school ☐ No insulin at Snack

Delivery Method

☐ Syringe/Pen ☐ Smart Pen – use pen suggestions

☐ Pump (Brand) _____

For Pumps:

☐ 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

☐ **Activity Mode (HCL pumps):**
Start _____minutes prior to exercise for _____minutes duration (DEFAULT 1 hr prior, during, and 2 hrs following exercise)

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 rapid acting 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.

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 rapid acting insulin by syringe or pen, and notify parents.
☐ For pump failure, only give correction dose if >___hrs since last rapid acting insulin

Insulin Calculation Directions: *(give number, not range)*
If only one given, time will be 7am to 4pm if not specified

Target bG =_____mg/dl (time _____to_____)

Target bG =_____mg/dl (time _____to_____)

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):

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

Carb Coverage:
gm carb in meal = X units insulin
gm carb in I:C

Correction Dose using ISF:
bG – Target bG = X units insulin
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.

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Student Last Name	**First Name**	**OSIS #**

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). You must include name and model of the CGM in use.

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

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 0.50u (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

OTHER ORDERS

HOME MEDICATIONS

☐ None

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 LAST	FIRST	SIGNATURE	DATE
PLEASE PRINT check one ☐ MD ☐ DO ☐ NP ☐ PA			

Address STREET	CITY/STATE	ZIP	**Email**

NYS License # (Required)	Tel	Fax	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**

疾病控制中心（CDC）和美國兒科學學會（AAP)推薦所有診斷為有糖尿病的兒童均接受每一年的季節流感免疫注射。

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家長/監護人：通讀、填寫並簽名。我在下面簽名，表示我同意如下：

1. 我同意，根據我子女保健專業人員的說明和所確定的技能水平，護士/校內健康中心（SBHC）可以為我的子女施用我子女的處方藥物，且護士/經訓練的教職工/SBHC提供者可以檢查我子女的血糖，並處理我子女的低血糖問題。這些措施可以在學校場地或在學校組織的外出參觀途中進行。
2. 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。
3. ***我理解：***

- 我必須將我子女的醫藥品、零食、器材及有關用品交給學校護士/SBHC提供者，並必須按需要補充這些醫藥品、零食、器材及有關用品。OSH建議使用安全採血針和其他安全針具及相應用品檢查我子女的血糖水平和補給胰島素。
- **我給予學校的所有處方和非處方藥物都必須是新的、未曾開封過並裝在其原封瓶子或盒子裏。我將給學校提供我子女在上學日內需使用的當前、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；**10)** 任何其他說明。
- 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/SBHC提供者。
- 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」（MAF）上簽名，表示授權學校健康辦公室（OSH）為我子女提供糖尿病相關的健康服務。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臨床評估或體檢。
- 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/SBHC提供者一份新的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/SBHC提供者一份新的由我子女的保健專業人員出具的MAF。
- OSH和教育局（DOE）確保我的子女能夠安全地測試其血糖。
- 這份表格表明我對本表所說明的糖尿病服務的同意和要求。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「第504款特別照顧計劃」（Section 504 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可以向任何為我子女提供健康服務的保健專業人員、護士或藥劑師索取該資訊。

用於詢問有關糖尿病藥物施用表（DMAF）的問題的OSH家長熱線：718-786-4933

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，我的子女在學校裏自己攜帶、儲存並施用本表格上所開具的藥物。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導致的任何後果。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，如果我的子女暫時無法攜帶藥品和用藥，而如果醫護人員開具處方，學校護士或受過訓練的學校員工可給我的子女施用可注射胰高血糖素和/或鼻噴用胰高血糖素（自2021年8月生效）。

註：最好是您在學校外出參觀的日子和在校外進行學校活動時給子女帶上藥物和器材。

學生姓氏：_____ 名字：_____ 中間名首字母：_____ 出生日期：_____

學校（ATS DBN/名稱）：_____ 行政區：_____ 學區：_____

家長/監護人姓名（用英文清楚書寫）：家長/監護人電子郵箱_____

家長/監護人簽名（A和B部分）：_____ 簽名日期：_____

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：_____ 電話號碼：_____

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For Office of School Health (OSH) Use Only

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

☐ **Clarified** ☐ **Modified**

Notes