糖尿病药物施用表（Diabetes Medication Administration Form）：
家长/监护人同意和授权
2013-2014 学年

我谨此授权：根据随附的我子女医生的説明，(1) 对我子女的血糖实行监测，(2) 提供医疗处方的治疗和/或 (3) 在学校场地对发生低血糖情况的治疗。我理解，我必须提供所有必需零食、器械和用品，并且如上述涉及的处方或説明出现任何变化，我必须立即通知校长和/或其指定人员（尤其是学校护士）。

我理解，这一授权的有效期只到以下一个时间（取其中较早的一个时间）爲止：(1) 2014 年 6 月 27 日（如果学生参加一个纽约市教育局资助的暑期教学计划，则该处方可以延长到整个的八月）； 或者 (2) 我给校长或其指定人士和护士送交一则新的处方或由我子女的医生签发的关于上述监测和治疗的説明的这一时间。

我知道，纽约市教育局及其代理机构与健康和心理卫生局（DOHMH）有责任确保医疗室以及我子女可能测试其血糖的任何其他场所的安全环境。我将尽一切努力为学校提供用于葡萄糖监测和胰岛素施用目的之安全刺血针和其他安全针头用品。

我递交这份「糖尿病药物施用表」（Diabetes Medication Administration Form），则表明我申请由教育局与纽约市健康和心理卫生局（New York City Department of Health and Mental Hygiene，简称 DOHMH）通过学校健康办公室（Office of School Health，简称 OSH）给我的子女提供具体健康服务。我理解，这些服务中的部分可能含有学校健康办公室的一名医生就我子女对处方药物之反应所作的评估。关于上述健康服务提供之要求的全面和完整的说明列入此表。我理解，与上述要求的健康服务的提供相关的教育局、健康和心理卫生局（DOHMH）及其代理机构和雇员需要本表各所提供资讯的精确性。根据这张表格所提供的资讯和指令让我的子女接受健康服务，完全是我的意愿。我也理解，教育局、健康和心理卫生局（DOHMH）及其代理机构对这一药物可能引起的任何副作用不承担责任。

我知道，这一表格并不是教育局以及健康和心理卫生局（DOHMH）提供所申请的服务的同意函，而是我要求这些服务的申请、同意和授权函。如果这些服务被确定为有必要提供，则一份「学生照顾计划」（Student Accommodation Plan ）可能也是有必要的，将由学校填写。

我谨此授权教育局、健康和心理卫生局（DOHMH）及其雇员和代理机构与任何健康服务提供者和/或药剂师联络和协商并获取任何他们认爲与我子女的医疗状况、药物和/或疗法相关的恰当额外资讯。

请在下面用英文填写家长/监护人的姓名和地址：

_____
家长/监护人签名

_____
签名日期

_____
日间电话号码/家庭电话哈马

_____

_____

_____

不要填写以下部分(FOR DOE AND DOHMH ONLY)

Student's Name:_____ OSIS No:_____

Received by: _____ _____ Reviewed by:_____ _____
Name Date Name Date

Referred to School 504 Coordinator: ☐ Yes ☐ No Self-Monitors: ☐ Yes ☐ No

Services provided by: ☐ Nurse ☐ DOHMH Public Health Adv. ☐ School Based Clinic ☐ DOE School Staff

Signature and Title:_____ _____
(RN OR SMD) (Date school notified and form forwarded to DOE liaison)

13-14

NYC OFFICE OF SCHOOL HEALTH – DIABETES MEDICATION ADMINISTRATION FORM

SCHOOL YEAR 2013-2014

Student Name				Sex ☐ Female ☐ Male	Date of Birth __ __ / __ __ / __ __ __ __ (Month Day Year)
ID Number __ __ __ __ __ __ __ __ __	DOE District __ __	School	Grade __ __	Class	Borough
School Address			Most Recent A1C Date ____/____/____ Result _____		

EMERGENCY SITUATIONS

Severe Hypoglycemia

☐ **Give Glucagon AND CALL 911**

PRN for unconsciousness, unresponsiveness, seizure, or inability to swallow EVEN if the bG is unknown. Turn onto left side to prevent aspiration.

☐ 1 mg SC/IM

☐ ___ mg SC/IM

Risk for Diabetic Ketoacidosis (DKA)

☐ **Ketones:** Test ketones if hyperglycemic*, vomiting, or fever ≥100.5

If small or trace, give water. Re-test ketones and bG in _____ hours

If initial or retest ketones are moderate or large, give water and:

☐ Call parent and/or MD ☐ No Gym

☐ If vomiting, unable to take PO, and MD not available, **CALL 911.**

☐ **Give insulin, if ordered below**

Diagnosis ☐ Type 1 Diabetes ICD9: _____ ☐ Type 2 Diabetes ICD9: _____

☐ Other: _____

Blood Glucose Monitoring and Insulin Orders

Student:

☐ May check bG without supervision ☐ May give insulin without supervision

☐ May check bG with supervision ☐ May give insulin with supervision

☐ Must have school personnel check bG ☐ Must have school nurse give insulin

	☐ **Lunch**	☐ **Snack**	☐ **Gym**	☐ **PRN**
Hypoglycemia	**For bG< _____ mg/dL** Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; if bG < _____ , repeat carbs and re-check until bG > _____ . THEN ☐ **Give insulin, BEFORE Lunch** ☐ **Give insulin AFTER Lunch**	**For bG< _____ mg/dL** Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; if bG < _____ , repeat carbs and re-check until bG > _____ . THEN ☐ **Give insulin BEFORE Snack** ☐ **Give insulin AFTER Snack**	**For bG< _____ mg/dL** Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; if bG < _____ , repeat carbs and re-check until bG > _____ . ☐ If initial bG < ____ , **No Gym** ☐ Give Snack **AFTER** treatment **THEN** send student to Gym	**For bG< _____ mg/dL** Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; if bG < _____ , repeat carbs and re-check until bG > _____ . ☐ Give Snack after treating Hypoglycemia
Between Hypo- and Hyperglycemia	☐ **Give insulin BEFORE Lunch** ☐ **Give insulin AFTER Lunch**	☐ **Give insulin BEFORE Snack** ☐ **Give insulin AFTER Snack**	☐ Give Snack **BEFORE** Gym ☐ Send to Gym	
Hyperglycemia* **bG > _____**	☐ **Test ketones if bG > _____ mg/dL** Treat as per Risk for DKA above ☐ **Give insulin BEFORE Lunch** ☐ **Give insulin AFTER Lunch**	☐ **Test ketones if bG > _____ mg/dL** Treat as per Risk for DKA above ☐ **Give insulin BEFORE Snack** ☐ **Give insulin AFTER Snack**	☐ **Test ketones if bG > _____ mg/dL** Treat as per Risk for DKA above For bG> _____ mg/dL **No Gym** For bG> _____ mg/dL AND at least ____ hours since last insulin, **give insulin**	☐ **Test ketones if bG > _____ mg/dL** Treat as per Risk for DKA above For bG> _____ mg/dL **No Gym** For bG> _____ mg/dL AND at least ____ hours since last insulin, **give insulin**
Carb Coverage Insulin Instructions	☐ Carb coverage ONLY ☐ Carb coverage PLUS Correction Dose when bG > Target bG	☐ Carb coverage ONLY ☐ Carb coverage PLUS Correction Dose when bG > Target bG		

INSULIN ORDERS (CHECK ONE BOX ONLY)

☐ Carb Coverage (plus Correction Dose if ordered above) ☐ Sliding Scale ☐ Carb Coverage plus Sliding Scale for Correction ☐ No Insulin at School Glucose Monitorning ONLY

☐ **Syringe/Pen**	**Name of Insulin**			☐ **Insulin Pump** *(Brand & Model)*		
Target (Single #) bG = _____ mg/dL	**Sensitivity Factor (Correction)** 1 unit will decrease bG by _____mg/dL	**Insulin:Carb Ratio:** (I:C)	For LUNCH 1:_____ gms	For SNACK 1:_____ gms	**Basal Rate(s):** In School _____ units/hour ☐ Gym _____ %	Temporary basal rate for _____ hours ☐ Disconnect Pump for gym
Target (Single #) bG = _____ mg/dL	**Sensitivity Factor (Correction)** 1 unit will decrease bG by _____mg/dL	**Insulin:Carb Ratio:** (I:C)	For LUNCH 1:_____ gms	For SNACK 1:_____ gms	**Basal Rate(s):** In School _____ units/hour ☐ Gym _____ %	Temporary basal rate for _____ hours ☐ Disconnect Pump for gym

Round DOWN the insulin dose to the closest 0.5 units for syringe/pen unless otherwise instructed by the PCP

Carb Coverage = $\frac{\text{\# gms carb in meal}}{\text{\# gms carb in I:C}}$ = _____ units insulin **Correction Dose** = $\frac{\text{bG – Target bG}}{\text{Sensitivity Factor}}$ = _____ units insulin

Example: Carb Coverage plus Correction Dose

Current bG = 250 Target bG=150 Sensitivity Factor = 100 Insulin:Carb ratio = 1:20 Lunch carbs = 60 gms

Carb Coverage: $\frac{60 \text{ gms carb}}{20}$ = 3 units **PLUS Correction Dose:** $\frac{250-150}{100}$ = **1 unit TOTAL DOSE: 3+1=4 units**

For Pump:

☐ Follow Pump recommendation for bolus dose [If not using Pump recommendation, round DOWN the dose down to nearest 0.1 unit]

☐ For bG > _____ mg/dL that has not decreased _____ hours after correction consider pump failure. Notify parent.

☐ For suspected pump failure: DISCONNECT pump and give insulin by syringe or pen

SLIDING SCALE

Name of Insulin

_____

Please do NOT overlap ranges (e.g. 100-200, 200-300, etc). If ranges overlap, the lower dose will be given.

☐ Pre lunch	bG Range	Insulin Units	☐ Other time _____	bG Range	Insulin Units
	_____	_____		_____	_____
	_____	_____		_____	_____
	_____	_____		_____	_____

SNACK:

Time of day: _____

Type & Amount:

☐ Student may carry and self administer snacks

HOME MEDICATIONS

Insulin *(Dose, Frequency, and Time)*

_____

Oral Medications *(Dose, Frequency, and Time)*

OTHER DIABETES ORDERS

_____

_____

_____

Health Care Practitioner Name *(Please Print)* FIRST NAME / LAST NAME			HCP Signature	
Address			Medicaid No.	NPI No.
Tel. No.	Fax. No.	NYS Lic. No. **(Required)**	Date __ __ / __ __ / __ __	

For DOHMH USE: Revisions per consult with Prescriber:

_____

_____

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS