Attach student photo here

DIABETES MEDICATION ADMINISTRATION FORM

☐ Addendum Attached

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 ☐ Pre-gym and/or ☐ PRN, **NO GYM**

☐ For bG > ___mg/DL or **and** mod/lg Ketones ☐ 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.**	

糖尿病藥物施用表

提供者醫療手續執行表 | 學校健康辦公室 | 2018-2019 學年

截止日期：7 月 15 日。7 月 15 日之後遞交的表格可能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） 傳著給 347-396-8932/8945.

家長/監護人填妥以下內容。

在下面簽名，則表示我同意：

1. 我同意，護士為我的子女施用我子女的處方藥物，我子女的學校檢查我子女的血糖並根據我子女保健專業人員的說明治療我子女的低血糖。學校可在學校場地或在學校旅行時間實施這些行動。
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：
   - 我必須把我子女的醫藥、零食和器材交給學校護士。我將盡可能把檢查我子女血糖水平和補給胰島素的安全采血針和其它安全針具及設備交給學校。
   - **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。**我將給子女另外再獲取一份藥物，供其在不上學時或在參加學校旅行時使用。
     - 處方藥物必須在其盒子或瓶子上有本來的藥房標籤。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) 任何其它說明。
   - 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。
   - 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，則學校健康辦公室（OSH）可以為我子女提供健康服務。這些服務可以包括由一名 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）。
   - 如果這份醫藥手續執行要求過期，而我子女的保健專業人員沒有出具一份新的 MAF，那麼一名 OSH 保健專業人員可以為我子女填寫一份新的糖尿病 MAF。**OSH 出具新的糖尿病 MAF 並不需要獲得我的簽名。**
   - OSH 和教育局（DOE）負責確保我的子女能夠在醫務室和任何學校地點能夠安全地測試其血糖。
   - 這份表格代表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「學生特別照顧計劃」（Student Accommodation Plan）。這份計劃將由學校填寫。
   - 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它資訊。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。
   - 如果學校護士不在，我可能會被通知前來學校為子女給藥。

自己用藥：

- 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藥物。

說明：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	MI	出生日期	學校
清楚填寫家長/監護人的姓名		**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	**住家**		**手機**	
其他緊急聯絡人姓名			**聯絡電話號碼**	

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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 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