DIABETES MEDICATION ADMINISTRATION FORM

Provider Medication Order Form—Office of School Health—School Year 2017-2018

Student Last Name First Name Middle	**Date of birth**_____/____/_____ MM DD YYYY	☐ 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**_____. **%**

EMERGENCY ORDERS

Severe Hypoglycemia

Administer **Glucagon** and **call 911**

☐ 1 mg SC/IM

☐ ___ mg SC/IM

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

Risk for Diabetic Ketoacidosis (DKA)

☐ Test **ketones** if bG > ___ mg/dl, or if vomiting, or fever ≥ 100.5F

- 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 PMD
  - ☐ 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

- ☐ Student may check bG without supervision.
- ☐ Student to check bG with nurse/school staff supervision.
- ☐ Nurse / school personnel must check bG.

INSULIN ADMINISTRATION SKILL LEVEL

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised student: student self-administers, under supervision
- ☐ Independent Student: Self-carry / Self-administer:*

_____ practitioner's initials

I attest student demonstrated the ability to self-administer the prescribed medication effectively for school, field trips, & school/sponsored events ***PARENT MUST INITIAL REVERSE SIDE**

MONITORING	☐ At LUNCH Time	☐ At SNACK Time**	☐ At GYM Time	☐ PRN
Hypoglycemia	**For bG< _ _ _ mg/dL** **Give** ___ oz juice, or ___ glucose tabs, or ___ grams carbs. **Re-check** in __ minutes; if bG <_ _ _ repeat carbs and re-check **until bG >_ _ _. THEN** Insulin is given **BEFORE** Lunch, **unless** otherwise indicated. ☐ Give insulin **AFTER** Lunch	**For bG< _ _ _ mg/dL** **Give** ___ oz juice, or ___ glucose tabs, or ___ grams carbs. **Re-check** in __ minutes; if bG <_ _ _ repeat carbs and re-check **until bG >_ _ _. THEN** Insulin is given **BEFORE** Snack, **unless** otherwise indicated. ☐ Give insulin **AFTER** Snack**	**For bG< _ _ _ mg/dL** **Give** ___ oz juice, or ___ glucose tabs, or ___ grams 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 to Gym	**For bG< _ _ _ mg/dL** **Give** ___ oz juice, or ___ glucose tabs, or ___ grams carbs. **Re-check** in minutes; if bG <_ _ _ repeat carbs and re-check **until bG >_ _ _.** ☐ Give Snack** **AFTER** treatment
	Use pre-treatment bG to calculate insulin dose, unless otherwise prescribed			
Between hypo & hyperglycemia	Insulin is given **BEFORE** Lunch, **unless** otherwise instructed. ☐ Give insulin AFTER Lunch	Insulin is given **BEFORE** Snack, **unless** otherwise instructed. ☐ Give insulin AFTER Snack**	☐ Give Snack** **BEFORE** Gym	
Hyperglycemia bG > _ _ _ mg/dL	Insulin is given **BEFORE** Lunch, **unless** otherwise instructed. ☐ Give insulin **AFTER** Lunch	Insulin is given **BEFORE** Snack, **unless** otherwise instructed. ☐ Give insulin **AFTER** Snack**	☐ For bG> _ _ _. No Gym ☐ For bG> _ _ _. AND at least _ hours since last insulin, give insulin correction	☐ For bG> _ _ _. No Gym ☐ For bG> _ _ _. AND at least _ hours since last insulin, give insulin correction
Carb Coverage Insulin Instructions	☐ Carb coverage **ONLY** ☐ Carb coverage **PLUS** Correction Dose when bG > Target bG AND at least __ hours since last insulin ☐ Correction Dose **ONLY**	☐ Carb coverage **ONLY** ☐ Carb coverage **PLUS** Correction Dose when bG > Target bG AND at least _ hours since last insulin ☐ Correction Dose **ONLY**	**SNACK Student may carry and self-administer snacks: ☐ Yes ☐ No Time of day_____AM _____PM Type, Amount _____ ☐ **NO INSULIN TO BE GIVEN AT SNACK TIME** ☐ **Hold snack if bG > _____ mg/dl**	

☐ **Correction Dose Method** (with or without Carb Coverage) using: ☐ Insulin Sensitivity Factor or ☐ Sliding Scale ☐ Sliding Scale ☐ Fixed Dose (enter time and dose in Other Orders box) ☐ No Insulin at School Glucose Monitoring ONLY

Name of Insulin:_____ **Delivery Method: ☐ Syringe ☐ Pen ☐ Insulin Pump (Brand):**

Target bG =	Insulin Sensitivity Factor (ISF)	Insulin to Carbohydrate Ratio (I:C)	Basal Rate In School	Basal Rate for Gym
_ _ _ mg/dL	**1 unit** decreases bG by_ _mg/dL	For LUNCH: 1 unit: per _ _ grams carbs For SNACK: 1 unit: per _ _ grams carbs	_ . _ units/hour _ _ to _ _ AM / PM _ . _ units/hour _ _ to _ _ AM / PM	_ _ _ . _ percent for ___ hours ☐ Disconnect Pump for gym

Correction Dose by ISF: bG – Target bG / Insulin Sensitivity Factor = ___ . ___ units insulin

Carb Coverage: # grams carb in meal / # grams carb in I:C = ___ . ___ units insulin

*Round **DOWN** insulin dose to the closest **0.5 unit** for syringe/pen or to the nearest **whole unit** if the syringe/pen doesn't have half-units: **unless** otherwise instructed by the PCP/endocrinologist.*

☐ **Follow Pump recommendation** for bolus dose (If not using Pump recommendation, round dose DOWN to nearest **0.1** unit).

☐ For bG > _ _ _ mg/dL that has not decreased __ hours after correction, consider pump failure and notify parent.

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

Sliding Scale

Do NOT overlap ranges (e.g., enter as 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given.

☐ Pre-Lunch ☐ Pre-Snack ☐ Correction dose	bG Range mg/dL		Insulin
	0		

☐ Other time	bG Range mg/dL		Insulin Units
	0		

Home Medications	Dose	Frequency	Time
Insulin:			
Oral:			

OTHER ORDERS (such as "Fixed Dose" orders, adjustments for rounding)

Health Care Practitioner (Please Print) LAST NAME FIRST NAME		Signature	Date __/__/____
Address		Tel. (___)___-____	Fax. (___)___-____
NYS License # **(Required)** _____	NPI # _____	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**	

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

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MONITORING BLOOD SUGAR, MEDICATION AND DIETARY NEEDS:

The Following Section To Be Completed By Student's **Parent/Guardian**

我謹此同意：

(1) 監察我子女的血糖；

(2) 提供醫療處方治療法； 和/或

(3) 根據所附的學生的保健專業人員的說明，在校園或學校自主的活動中施用低血糖發作的治療法。

我謹此授權藥物的儲藏和施用以及根據我子女的保健專業人員的指導為施用該藥物而必需的器械的儲藏和使用。我理解，我必須給學校提供施用藥物所必需的藥物和器械（包括非Ventolin吸入器）。藥物應置於一個來自藥房並正確標示的原裝容器（我應為我子女在學校之外的使用另外配得一個如此的容器）；處方藥物的標示必須包含學生姓名、藥房名稱和電話號碼、執照開處方醫生的姓名和日期及再拿葯的次數、藥物的名稱和劑量及施用頻率、施用規程和/或其他說明；櫃檯購買的藥品和藥物樣本必須裝在藥廠原裝的容器裏，容器上附有學生姓名。**我理解，如果我提供任何藥物，該藥物必須以其原裝和未開封的藥物包裝盒提供。**我理解，我必須提供所有必需零食、器械和用品，並且如上述處方或說明出現任何變化，我必須立即通知學校護士。

我理解，這份同意函的有效期只持續到一個由紐約市教育局（DOE）資助的暑期教學計劃時段結束爲止，或者到我將我子女的保健專業人員簽發的關於上述說明的監督和治療的使用之最新處方或說明交給學校護士這一時間爲止（以這兩者中較早的時間為准）。

我知道，紐約市健康和心理衛生局（New York City Department of Health and Mental Hygiene，簡稱"DOHMH"）、教育局及其代理機構有責任確保醫療室以及我子女可能測試其血糖的任何其他場所的安全環境。我將盡一切努力為學校提供用於葡萄糖監測和胰島素施用目的之安全刺血針和其他安全針頭用品。

我遞交這份「糖尿病藥物施用表」（Diabetes Medication Administration Form），則表明我申請由紐約市健康和心理衛生局（DOHMH）通過學校健康辦公室（Office of School Health，簡稱OSH）給我的子女提供具體健康服務。我理解，這些服務可能包括由一名OSH辦公室的保健專業人員所執行的一次臨床評估和/或體檢。關於上述健康服務提供之要求的全面和完整的說明列入此表。我理解，與上述要求的健康服務的提供相關的學校健康辦公室及其代理機構和僱員需要本表格所提供資訊的精確性。我知道，這一表格並不是學校健康辦公室或教育局同意提供所申請服務的同意函，而是我要求這些服務的申請和同意函。如果這些服務被確定為有必要提供，則一份「學生照顧計劃」（Student Accommodation Plan ）可能也是有必要的，將由學校填寫。

我理解，學校健康辦公室和教育局及其僱員和代理機構可以與任何給我子女提供醫療或健康服務的保健專業人員和/或藥劑師聯絡和協商並獲取任何他們認爲與我子女的醫療狀況、藥物和/或療法相關的恰當額外資訊。

學生自己用藥：

請在這段簽上您姓名的首字母，讓您的子女可以自己使用epinephrine、哮喘吸入器及其他經批准可自己使用的藥物：

_____ 姓名首字母	我謹此證明，我的子女已經獲得全面的指導，有能力自己施用該處方藥物。我也同意我子女在學校攜帶、儲藏和自己使用上述處方藥物。我知道，我要負責給我的子女提供如此藥物：該藥物必須置於如以上所描述而標示的容器中；我要負責對我子女使用此藥物的任何和所有的監督；並負責我子女因在學校使用此藥物而導致的任何或所有後果。我理解，學校護士將確認我子女是否具有以負責的方式自己攜帶和自己施用藥物的能力。另外，我同意提供一份置於一個清楚標寫的容器中的「後備」藥物，該藥物將被保存在醫務室，在我子女沒有足夠藥物自己施用的情況下備用。
_____ 姓名首字母	我同意，萬一我的子女臨時無法自己儲藏和自己施用該藥物時，學校護士可以儲存此藥物和/或給我的子女施用該藥物。

在此簽名

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		**家長/監護人簽名**	
家長/監護人地址		簽名日期	
電話號碼	日間 住家		手機
家長/監護人電子郵箱地址			
其他緊急聯絡人姓名		聯絡電話號碼	

DO NOT WRITE BELOW – FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

Received by: Name Date	Reviewed by: Name Date
bG monitoring without supervision: ☐ Yes ☐ No	Insulin administration without supervision: ☐ Yes ☐ No
Services provided by: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center	
Signature and Title (RN OR MD/DO/NP)	
Revisions per OSH after consultation with prescribing health care practitioner.	

*Confidential information should not be sent by e-mail.