Student Last Name	First Name	MI	**Date of birth**_____/_____/ _____	**School**

KONTWÒL SIK NAN SAN, BEZWEN POU BAY MEDIKAMAN AK POU SUIV YON REJIM ALIMANTÈ :
KONSANTMAN PARAN/RESPONSAB POU 2016-2017

Nan papye sa a, mwen bay konsantman m pou:
(1) kontwòle kantite sik nan san pitit mwen an ;
(2) bay pitit mwen tretman doktè preskri li ak/oswa;
(3) bay pitit mwen an tretman lè sik li desann twò ba nan building lekòl la oswa nan aktivite lekòl la patwone dapre eksplikasyon ajan sante li ki vini avèk lèt sa a.

Nan dokiman sa a, mwen bay otorizasyon pou yo bay pitit mwen an medikaman li ak pou yo mete medikaman an ansanm avèk ekipman nesesè pou ba l medikaman an nan kabinè enfimri lekòl la, dapre rekòmandasyon doktè pitit mwen an. Mwen rekonèt mwen dwe bay lekòl la medikaman an ak ekipman nesesè pou bay medikaman, tankou ponp pou opresyon non-Ventolin inhalers. Mwen rekonèt mwen dwe bay medikaman an nan flakon famasi vann li a ak tout etikèt li (mwen dwe mande famasi a yon lòt flakon orijinal pou pitit mwen itilize nan lekòl la); etikèt ki sou medikaman doktè preskri a dwe gen non elèv la, non ak nimewo telefòn famasi a, non doktè ki preskri medikaman an, dat ak kantite fwa yo ka renouvle preskripsyon an, non medikaman an, dòz yo preskri a, kantite fwa pou yo bay timoun lan medikaman an, jan pou yo bay li ak/oswa lòt enstriksyon; yo dwe kite medikaman yo vann san preskripsyon ak echantiyon medikaman nan flakon orijinal fabrikan an yo, avèk non elèv la sou flakon an. Mwen konnen nenpòt medikaman mwen bay, mwen dwe bay li nan bwat orijinal medikaman an ki PAKO OUVRI. Mwen rekonèt mwen dwe founi tout ekipman, medikaman ak snack ki nesesè, epi tou mwen dwe avèti imedyatman enfimyè lekòl la si gen nenpòt chanjman nan preskripsyon an oswa nan eksplikasyon ki pi wo a.

Mwen konprann konsantman sa a valab jis nan fen sesyon pwogram ansèyman pandan ete Depatman edikasyon Vil Nouyòk patwone a sèlman; oswa lè mwen bay enfimyè lekòl la yon nouvo preskripsyon oswa enstriksyon ajan sante pitit mwen an bay osijè kòman pou yo fè siveyans ak tretman pi wo a (nenpòt sa ki vin avan an).

Mwen rekonèt Depatman Sante ak Ijyèn Mantal (DOHMH), DOE, ak moun ki reprezante l yo, gen responsablite garanti yon anviwònman sandanje nan enfimri a ak tout lòt kote pitit mwen an ka teste nivo sik nan san li. M ap fè tout efò pou bay lekòl la lansèt ak lòt ekipman pou pèmèt antre zegwi yo ak plis fasilite pou kontwole kantite sik nan san pitit mwen an e pou administre l ensilin.

Lè m soumèt fòm pou yo bay medikaman dyabèt la, mwen mande pou DOHMH bay pitit mwen sèvis sante espesifik atravè Biwo sante lekòl (OSH). Mwen konprann kapab gen nan sèvis sa yo ki oblije yon ajan swen sante OSH fè yon evalyasyon klinik ak yon konsiltasyon fizik. Nou mete tout enstriksyon konsènan fason pou ofri sèvis sante yo mande pi wo a nan Fòm sa a. Mwen konnen OSH, reprezantan yo, ak anplwaye k ap ede ofri sèvis sante yo mande pi wo a konte sou presizyon enfòmasyon moun bay nan fòm sa a. Mwen rekonèt fòm sa a pa reprezante yon kontra OSH ni DOE pou bay sèvis mwen mande yo, men li reprezante pito demann mwen fè pou sèvis sa yo ak konsantman mwen pou pitit mwen an resevwa sèvis sa yo. Si yo wè sèvis sa yo nesesè, li ka nesesè tou pou tabli yon plan akomodasyon pou elèv la, epi lekòl la ap fè plan.

Mwen konprann OSH ak DOE ak anplwaye yo, ak moun ki reprezante yo kapab kontakte, mande avi tout founisè sèvis sante ak/oswa famasyen ki founi pitit mwen an sèvis sante ak/oswa tretman pou jwenn tout lòt enfòmasyon yo ka jije apwopriye osijè eta sante pitit mwen an, medikaman li pran ak/oswa tretman y ap ba li.
****MEDIKAMAN POU TIMOUN LAN PRAN POUKONT LI : Mete inisyal ou akote paragraf sa a pou itilizasyon yon epinephrine, ponp medikaman pou opresyon ak lòt medikaman yo apwouve pou timoun lan pran poukont li):**
_____ Mwen sètifye la a yo byen montre pitit mwen an jan pou l pran medikaman yo preskri l la poukont li, epi li ka pran l poukont li. Mwen konsanti tou pou pitit mwen an pote, konsève ak pran medikaman ki preskri pi wo a poukont li nan lekòl la. Mwen rekonèt se responsablite m pou bay pitit mwen an medikaman sa a nan flakon ki gen etikèt jan yo dekri sa pi wo a, pou kontwole jan pitit mwen ititlize medikaman sa a, epitou pou nenpòt konsekans ki rive akoz pitit mwen ap ititlize medikaman sa a nan lekòl la. Mwen konnen enfimyè lekòl la ap konfime kapasite pitit mwen an pou pote ak pou pran medikaman an poukont li yon fason responsab. Anplis, mwen dakò pou bay lekòl la "lòt flakon" medikaman ki gen etikèt kote yo ekri aklè non medikaman an pou konsève nan enfimri lekòl la si pitit mwen an pa ta rete ase nan medikaman li pote pou pran poukont li.
_____ Mwen bay konsantman m pou enfimyè lekòl la pou kenbe nan lekòl la ak/oswa bay pitit mwen an medikaman sa a nan ka kote pitit mwen an pa ta kapab kenbe oswa pran medikaman sa pou kont li pou yon ti bout tan.

Siyati Paran/Responsab	**Ekri ak lèt detache Non Paran/Responsab**
Dat ou siyen ____/_____/ _____	**Adrès Paran/Responsab**
Nimewo telefòn: **Lajounen** (_____)_____-_____ **Lakay** (_____)_____-_____ **Selilè*** (_____)_____- _____	
Adrès imèl Paran/Responsab*	
Lòt non moun nou ka kontakte lè gen yon ijans	**Nimewo telefòn moun pou kontakte** (_)_____- _____

PA EKRI PI BA A - PLAS SA A REZÈVE POU BIWO OSH SÈLMAN (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.	

DIABETES MEDICATION ADMINISTRATION FORM – OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication in School to Students for School Year 2016-2017

Student Last Name	First Name	Middle	**Date of birth**_____/____/_____ M M D D Y Y Y Y	☐ 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 hyperglycemic, vomiting, or fever ≥100.5
- 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

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

INSULIN ADMINISTRATION

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised student: student self-administers, under adult supervision
- ☐ Independent Student: Self-carry / Self-administer:*
  I attest student demonstrated the ability to self-administer the prescribed medication effectively for school/field trips/school/sponsored events: _____ (practitioner's initials)

***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	**Test ketones if bG> _ _ _ mg/dL and manage as above for DKA:** applies to all times (otherwise use space in Other Orders)			
	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	☐ Carb coverage **ONLY** ☐ Carb coverage **PLUS** Correction Dose when bG > Target bG AND at least _ hours since last insulin	****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**	

INSULIN ORDERS (CHECK ONE)	☐ **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: ☐ **Syringe** ☐ **Pen** ☐ **Insulin Pump (Brand):**

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

☐ **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.

*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.*

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. (_ _ _)_ _ _- _ _ _ _	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**
NYS License # **(Required)** _____	Medicaid# _ _ _ _ _ _ _ _ _ _	NPI # _ _ _ _ _ _ _ _ _ _	

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

Rev 5/16