Attach student photo here

DIABETES MEDICATION ADMINISTRATION FORM

Provider Medication Order Form – Office of School Health – School Year **2018-2019**

☐ Addendum Attached

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 **and** mod/lg Ketones ☐ Pre-gym and/or ☐ PRN – **NO GYM**
☐ For bG > ___mg/DL or ☐ 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:
$\frac{\text{bG} - \text{Target bG}}{\text{ISF}} = X$ 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.**	

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS FORMS CANNOT BE COMPLETED BY A RESIDENT

FÒM POU MANDE BAY MEDIKAMAN KONT DYABÈT

Fòm Kòmand Medikaman Founisè | Biwo Sante Lekòl | Ane Lekòl 2018–2019

DELÈ : 15 JIYÈ. Fòm yo resevwa apre 15 jiyè ka retade pwosesis la pou nouvo ane lekòl la Tanpri fakse tout DMAF nan 347-396-8932/8945.

PARAN/RESPONSAB RANPLI PATI PI BA A

Lè m siyen pi ba, mwen dakò avèk bagay sa yo:

1. Mwen dakò pou enfimyè a bay pitit mwen an medikaman yo preskri yo ak pou lekòl pitit mwen tcheke nivo sik nan san pitit mwen an epi pou trete nivo sik nan san pitit mwen an dapre rekòmandasyon doktè k ap pran swen pitit mwen an. Lekòl la ka pran mezi sa yo sou lakou lekòl oswa pandan pwomnad lekòl yo.
2. Mwen dakò tou pou yo konsève nenpòt ekipman yo bezwen pou yo ka konsève medikaman pitit mwen an ak itilize l nan lekòl la.
3. Mwen konprann ke:
   - Mwen dwe bay enfimyè lekòl la medikaman, snack ak ak ekipman pitit mwen an. M ap eseye bay lekòl la lansèt sekirite yo ak lòt egwi sekirite ak ekipman pou tcheke nivo sik nan san pitit mwen an ak ba li ensilin.
   - **Tout medikaman ak preskripsyon ak tout medikaman "ki vann san preksripsyon (over-the-counter)" fèt pou nèf, kachte nan bwat oswa boutèt orijinal la.** M ap gen yon lòt medikaman pou pitit mwen pran lè li pa lekòl oswa lè li nan yon pwomnad lekòl.
     - Medikaman ki vann ak preskripsyon yo fèt pou gen etikèt orijinal famasi a sou bwat la oswa sou boutèy la. Etikèt la dwe gen ladan: 1) non pitit mwen an, 2) non ak nimewo telefòn famasi a, 3) non doktè pitit mwen an, 4) dat, 5) kantite rechaj (refills), 6) non medikaman an, 7) dozaj, 8) lè pou li pran l, 9)kòman pou li pran medikaman an ak 10) nenpòt lòt eksplikasyon.
   - Mwen dwe di enfimyè lekòl la **imedyatman** nenpòt chanjman ki genyen nan medikaman pitit mwen an oswa nan eksplikasyon doktè k ap trete l.
   - Biwo Sante nan Lekòl (Office of School Health, OSH) ak ajan li ki patisipe nan ofri pitit mwen an sèvis sante ki pi wo yo konte sou presizyon ki nan enfòmasyon ki sou fòm sa a.
   - Lè m siyen fòm pou bay medikaman sa a (medication administration form, MAF) sa a, OSH ka bay pitit mwen an sèvis sante. Sèvis sa yo ka genyen yon evalyasyon klinik oswa yon konsiltasyon medikal yon doktè oswa yon enfimyè OSH fè.
   - Lòd pou bay medikaman ki sou fòm MAF sa a ekspire nan fen ane lekòl pitit mwen an, ki ka gen ladan tou sesyon ete, oswa lè mwen bay enfimyè lekòl la yon nouvo fòm MAF (kèlkeswa sa ki rive avan an).
   - Si medikaman sa a ekspire, epi doktè pitit mwen an pa bay yon nouvo fòm MAF, yon doktè OSH ka ranpli yon nouvo fòm MAF pou pitit mwen an. **OSH pa p bezwen siyati m pou l ekri lòt fòm MAF kont dyabèt alavni.**
   - OSH ak Department of Education (DOE) responsab pou asire yo pitit mwen an ka tcheke nivo sik nan san l nan sal medikal la ak nenpòt kote nan lekòl la.
   - Fòm sa a reprezante konsantman m ak demand mwen fè pou sèvis dyabèt yo dekri sou fòm sa a. se pa yon akò OSH genyen pou li bay sèvis ou mande a. Si OSH deside ofri sèvis sa yo, pitit mwen an ka bezwen tou yon Plan Akomodasyon pou Elèv (Student Accommodation Plan). Se lekòl la k ap ranpli plan sa a.
   - OSH ka gen nenpòt lòt enfòmasyon yo panse ki nesesè sou pwoblèm medikal pitit mwen an, medikaman l ap pran oswa tertman l swiv. OSH ka pran enfòmasyon sa a nan men nenpòt doktè, enfimyè oswa famasyen ki bay pitit mwen an sèvis.
   - Si enfimyè lekòl la pa disponib, yo ka avèti m pou m vin lekòl la pou bay pitit mwen an medikaman.

MEDIKAMAN POU TIMOUN LAN PRAN POUKONT LI :

- Mwen sètifye/konfime pitit mwen an resevwa bon jan trening epi li kapab pran medikaman poukont li. Mwen dakò pou pitit mwen an pote, konsève ak pran poukontli medikaman yo preskri nan fòm sa a nan lekòl la. Mwen gen responsablite pou bay pitit mwen an medikaman sa a nan boutèy oswa nan bwat yo jan yo dekri sa pi wo a. Mwen gen responsablite pou m sipèvize itilizasyon medikaman pitit mwen an ak pou tout konsekans ki genyen nan itilizasyon medikaman pitit mwen an pran nan lekòl la. Enfimyè lekòl la pral konfime kapasite pitit mwen an pou l pote ak pran medikaman yo poukont li. Mwen dakò tou pou m bay lekòl la medikaman "an rezèv" nan yon bwat oswa boutèy ki gen etikèt byen klè sou li.
- Mwen dakò pou enfimyè lekòl la oswa manm estaf ki resevwa trening bay pitit mwen an medikaman si li pa kapab pote ak pran yo poukont li pou yon ti tan.

SONJE: Li pi bon si w voye medikaman ak ekipman pou pitit ou a nan jou yon pwomnad lekòl ak nan aktivite k ap fèt andeyò lokal lekòl la.

Siyati **elèv** la Non Inisyal dezyèm non		Dat nesans	Lekòl
Ekri ak Non Paran/Responsab la byen klè	**SIYEN LA A**	**Siyati paran/responsab**	
Dat ou siyen fòm lan	**Imèl paran/responsab la**	**Adrès Paran/Responsab**	
Nimewo telefòn: **Lajounen**	**Kay**	**Selilè**	
Lòt non moun nou ka kontakte lè gen yon ijans		**Nimewo telefòn moun pou kontakte**	

For Office of School Health (OSH) Use Only / Pou Itilizasyon Biwo Sante Lekòl Sèlman

OSIS Number:		☐ **504** ☐ **IEP** ☐ **Other**	
Received by: Non	Dat	**Moun ki revize l**: Non	Dat
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			

*Ou pa dwe voye enfòmasyon konfidansyèl pa imèl.