Attach student photo here

DIABETES MEDICATION ADMINISTRATION FORM

Provider Medication Order Form – Office of School Health – School Year **2019-2020**

DUE: May 31st. Forms submitted after May 31st 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 ATSDBN/name, address and borough)			**DOE District**	**Grade**	**Class**

HEALTH CARE PRACTITIONER COMPLETES BELOW

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ non-Type 1/Type 2 Diabetes ☐ Other Diagnosis: Recent A1C: Date / / Result . %

Orders written will be for Sept. '19 through Aug '20 school year unless checked here: ☐ Current School Year '18-'19

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.

For Independent or supervised student: a trained adult will carry glucagon on school trips.

Risk for Ketones or Diabetic Ketoacidosis (DKA)
☐ Test **ketones** if bG >___mg/dl, or if vomiting, or fever > 100.5F **OR**
☐ Test ketones if bG >__mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5F
- If small or trace give water; re-test ketones & bG in 2 hrs or ___ hrs
- If initial or retest ketones are moderate or large, give water:
  Call parent and Endocrinologist; ☐ **NO GYM**
  If ketones and vomiting, unable to take PO and MD not available, **CALL 911**

☐ Give insulin correction dose if > 2 hrs or __ 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 *(Initial below)*
NOTE: Trip nurse not required for supervised or independent students.

I attest student demonstrated the ability to self-administer the prescribed medication effectively for school, field trips, & school/sponsored events — PROVIDER INITIALS

bG Monitoring: Specify times to test in school (must match times for treatment and/or insulin) ☐ Breakfast ☐Lunch ☐ Snack ☐ Gym ☐ PRN
☐ Use CGM readings **(must complete DMAF Addendum form)**

Hypoglycemia: *Check all boxes needed. Must include at least one treatment plan.*
☐ For bG < _____mg/dl give _____ gm rapid carbs 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 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.
Insulin is given before food unless otherwise noted here: ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

Snack orders on DMAF Addendum

15 gm rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz. juice

Mid-range Glycemia:
Insulin is given before food unless otherwise noted here: ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give snack before gym

Hyperglycemia:
Insulin is given before food unless otherwise noted here: ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give correction dose pre-meal and carb coverage after meal
☐ No Gym For bG > ___mg/DL ☐ Pre-gym and/or ☐ PRN
☐ For bG > ___ mg/dL PRN, Give insulin correction dose if > __ hrs. since last insulin
☐ 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:
Name of Insulin:
_____
☐ No Insulin in School
☐ No Insulin at Snack time

Delivery Method:
☐ Syringe/Pen
☐ Pump *(Brand)*: _____
☐ Smart Pen – use pen suggestions
☐ Parent may have input into insulin dosing. **See DMAF Addendum.**

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 2 hrs or ___ hrs. since last insulin at ☐ Breakfast ☐ Lunch ☐ Snack
Correction dose calculated using: ☐ ISF **or** ☐ Sliding Scale
☐ Fixed Dose (**see Other Orders**) (**See Addendum**)
☐ Sliding Scale (**See Addendum**)
☐ If Gym/recess is immediately following lunch, subtract ___ gm carbs from lunch carb calculation.
Use pre-treatment bG to calculate insulin dose unless otherwise ordered.

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 _____)
If only one ISF, time will be 8am to 4pm if not specified.

Insulin to Carb Ratio (I:C):
Lunch:
1 unit per ___ gms carbs **OR** time:_____to _____
Snack:
1 unit per ___ gms carbs **OR** time:_____to _____
Breakfast:
1 unit per ___ gms carbs **OR** time:_____to _____

Carb Coverage:
gm carb in meal = X units insulin
gm carb in I:C

Correction Dose using ISF:
bG – Target bG = X units insulin
ISF

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:
__:___ AM/PM to __:__ AM/PM __:___ units/hr
__:___ AM/PM to __:__ AM/PM __:___ units/hr
__:___ AM/PM to __:__ AM/PM __:___ units/hr
☐ 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

Other Orders:

Home Medications (in case of emergency e.g. school lock down)

Medication	Dose	Frequency	Time	Route
Insulin:				
Other:				

Health Care Practitioner Name LAST (**Please print and circle one:** MD, DO, NP, PA)	FIRST	Signature	Date
Address		Tel. (__ __ __) __ __ __ - __ __ __ __	Fax. (__ __ __) __ __ __ - __ __ __ __
NYS License # **(Required)**	NPI #	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**	

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PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to the nurse giving my child's prescribed medicine, and the nurse/trained staff checking their blood sugar, and treating their low blood sugar based on the directions and skill level determined by my child's health care practitioner. These actions may be performed on school grounds or during school trips.
2. I also consent to any equipment needed for my child's medicine being stored and used at school.
3. I understand that:
   - I must give the school nurse my child's medicine, snacks, equipment, and supplies and must replace such medicine, snacks, equipment and supplies as needed. OSH recommends the use of safety lancets and other safety needle devices and supplies to check my child's blood sugar levels and give insulin.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this Medication Administration Form (MAF), I authorize OSH to provide diabetes-related health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier).
   - OSH and the Department of Education (DOE) are responsible for making sure that my child can safely test his or her blood sugar.
   - This form represents my consent and request for the diabetes services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment for my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

FOR SELF-ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __
School ATSDBN/Name	Borough		District
Print Parent/Guardian's Name	**SIGN HERE** **Parent/Guardian's Signature**		Date Signed __ __ / __ __ / __ __ __ __
Parent/Guardian's Email	**Parent/Guardian's Address**		

Telephone Numbers: **Daytime** (__ __ __) __ __ __ - __ __ __ __ **Home** (__ __ __) __ __ __ - __ __ __ __ **Cell Phone** (__ __ __) __ __ __ - __ __ __ __

Alternate Emergency Contact's Name	**Relationship to Student**	**Contact Telephone Number** (__ __ __) __ __ __ - __ __ __ __

For Office of School Health Use Only

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 per OSH after consultation with prescribing health care practitioner ☐ Modified ☐ Not Modified

*Confidential Information should not be sent by email

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