NYC Health | Office of School Health

Diabetes Medication Administration Form [Part A]

Provider Medication Order Form | School Year 2021-2022

DUE: June 1st. Forms submitted after June 1st may delay processing for new school year. **Please fax all DMAFs to 347-396-8932/8945**

Student Last Name	First Name	Date of Birth	☐ Male ☐ Female	**OSIS #**

School ATSDBN / Name	Address	Borough	DOE District	Grade	Class

HEALTH CARE PRACTITIONER COMPLETES BELOW *[Please see 'Provider Guidelines for DMAF Completion']*

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Non-Type 1/Type 2 Diabetes

☐ Other Diagnosis: _____

Recent A1C

Date _____ /_____ /_____ Result _____ . _____%

Orders written will be for Sept. '21 through Aug '22 school year unless checked here ☐ **Current School Year '19-'20 and '20-'21**

EMERGENCY ORDERS

Severe Hypoglycemia
Administer Glucagon and CALL 911

Glucagon	GVOKE	Baqsimi	Zegalogue
☐ 1 mg	☐ 1 mg	☐ 3 mg	☐ 0.6 mg SC
☐_____mg SC/IM	☐_____mg SC/IM	Intranasal	may repeat in 15 min if needed

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 for the 2nd time that day (at least 2 hrs. apart),

☐ Test ketones if bG > _____ mg/dl or if vomiting or fever > 100.5F

► If small or trace give water; re-test ketones & bG in 2 hrs or _____ hrs

► If 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.

SKILL LEVEL

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
(MUST Initial attestation) I attest that the independent student demonstrated the ability to self-administer the prescribed medication effectively during school, field trips and school sponsored events _____ Provider Initials

BLOOD GLUCOSE MONITORING [See Part B for CGM readings]

Specify times to test in school (must match times for treatment and/or insulin) ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

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 > _____

☐ 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 > _____

☐ T2DM - no bG monitoring or insulin in school

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

☐ For bG < _____ mg/dl pre-gym, no gym ☐ For bG < _____ mg/dl ☐ Pre-gym ☐ PRN; treat hypoglycemia then give snack.

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

Hyperglycemia *Insulin is given before food unless noted here* ☐ Give insulin after ☐ Breakfast ☐ Lunch ☐ Snack

☐ No Gym For bG > _____ mg/dl ☐ Pre-gym and/or ☐ PRN

☐ For bG > _____ mg/dl PRN, Give insulin correction dose if > 2 hrs or _____ hrs. since last insulin For bG meter reading "High" use bG of 500 or _____ mg/dl

☐ **Check bG or Sensor Glucose (sG) before dismissal** ☐ *Give correction dose pre-meal and carb coverage after meal*

☐ *For sG or bG values <* _____mg/dl *treat for hypoglycemia if needed, and give* _____*gm carb snack before dismissed*

☐ *For sG or bG values <* _____mg/dl *treat for hypoglycemia if needed, and do not send on bus/mass transit, parent to pick up from school.*

INSULIN ORDERS

Insulin Name*

_____
**May substitute Novolog with Humalog/Admelog*

☐ No Insulin in School ☐ No Insulin at Snack

Delivery Method

☐ Syringe/Pen ☐ Smart Pen – use pen Suggestions

☐ Pump (Brand) _____

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) ☐ Sliding Scale (See Part B)
☐ If gym/recess is immediately following lunch, subtract _____carbs from lunch calculation.

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.

Carb Coverage	**Correction Dose using ISF**
# gm carb in meal = X units insulin / # gm carb in I:C	bG – Target bG = 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.

Insulin to Carb Ratio (I:C)

Bkfast OR time _____ to _____
1 unit per _____ gms carbs
Snack OR time _____ to _____
1 unit per _____ gms carbs
Lunch OR time _____ to _____
1 unit per _____ gms carbs
Lunch followed by gym _____ to _____
1 unit per _____ gms carbs

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 _____ hrs 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.

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT **HEALTH CARE PRACTITIONERS: COMPLETE 'PART B' AND SIGN ➔**

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Diabetes Medication Administration Form [Part B]

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Student Last Name	First Name		**OSIS #**

CONTINUOUS GLUCOSE MONITORING (CGM) ORDERS *[Please see 'Provider Guidelines for DMAF Completion']*

☐ Use CGM readings - For CGM's used to replace finger stick bG readings, only devices FDA approved for use and age may be used within the limits of the manufacturer's protocol. (sG = sensor glucose).

Name and Model of CGM

For CGM used for insulin dosing: finger stick bG will be done when: the symptoms don't match the CGM readings; if there is some reason to doubt the sensor (i.e. for readings <70 mg/dl or sensor does not show both arrows and numbers). ☐ CGM to be used for insulin dosing and monitoring — **must be FDA approved for use and age**

sG Monitoring Specify times to check sensor reading ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN [if none checked, will use bG monitoring times] For sG < 70mg/dl check bG and follow orders on DMAF, unless otherwise ordered below. Use CGM grid below OR ☐ See attached CGM instruction

CGM reading	**Arrows**	**Action** ☐ use < 80 mg/dl instead of < 70 mg/dl for grid action plan
sG < 60 mg/dl	Any arrows	Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.
sG 60-70 mg/dl	and ↓, ↓↓, ↘ or →	Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.
sG 60-70 mg/dl	and ↑ , ↑↑, or ↗	If symptomatic, treat hypoglycemia per bG hypoglycemia plan; if not symptomatic, recheck in 15-20 minutes. If still <70 mg/dl check bG.
sG >70 mg/dl	Any arrows	Follow bG DMAF orders for insulin dosing
sG ≤ 120 mg/dl pre-gym or recess	and ↓, ↓↓	Give 15 gms uncovered carbs. If gym or recess is immediately after lunch, subtract 15 gms of carbs from lunch carb calculation.
sG ≥ 250	Any arrows	Follow bG DMAF orders for treatment and insulin dosing

☐ For student using CGM, wait 2 hours after meal before testing ketones with hyperglycemia.

PARENTAL INPUT INTO INSULIN DOSING

Parent(s)/Guardian(s) (give name),_____, may provide the nurse with information relevant to insulin dosing, including dosing recommendations. Taking the parent's input into account, the nurse will determine the insulin dose within the range ordered by the health care practitioner and in keeping with nursing judgment.

Please select ONE option below

☐ Nurse may adjust calculated dose up or down up to _____ units based on parental input and nursing judgment.

☐ Nurse may adjust calculated dose up by _____% or down by _____% of the prescribed dose based on parental input and nursing judgment

MUST COMPLETE Health care practitioner can be reached for urgent dosing orders at: (_____) _____ - _____ If the parent requests a similar adjustment for > 2 days in a row, the nurse will contact the health care practitioner to see if the school orders need to be revised.

SLIDING SCALE

Do NOT overlap ranges (e.g. enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. Use pre-treatment bG to calculate insulin dose unless other orders.

☐ Lunch ☐ Snack ☐ Breakfast ☐ Correction Dose	**bG**	**Units Insulin**	Other Time :	**bG**	**Units Insulin**
	Zero –			Zero –	
	–		☐ Lunch ☐ Snack ☐ Breakfast ☐ Correction Dose	–	
	–			–	
	–			–	
	–			–	
	–			–	
	–			–	

OPTIONAL ORDERS

☐ Round insulin dosing to nearest whole unit: 0.51-1.50u rounds to 1.00u.

☐ Round insulin dosing to earest half unit: 0.26-0.75u rounds to 0.50 u (must have half unit syringe/pen).

☐ Use sliding scale for correction AND at meals ADD:

_____ units for lunch;

_____ units for snack;

_____ units for breakfast

(sliding scale must be marked as correction dose only).

☐ Long acting insulin given in school

Dose _____ units

Time _____ or ☐ Lunch

Insulin Name

SNACK ORDERS

☐ Student may carry and self-administer snack	Snack time of day AM / PM	Type & amount of snack

OTHER ORDERS

HOME MEDICATIONS ☐ None

Medication	**Dose**	**Frequency**	**Time**	**Route**
Insulin				
Other				

ADDITIONAL INFORMATION

Is the child using altered or non-FDA approved equipment? ☐ **Yes** or ☐ **No** *[Please note that New York State Education laws prohibit nurses from managing non-FDA devices. Please provide pump-failure and/or back up orders on DMAF Part A Form.]*

By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s).

Health Care Practitioner LAST	FIRST	SIGNATURE	DATE
PLEASE PRINT check one ☐ MD ☐ DO ☐ NP ☐ PA			

Address STREET	CITY/STATE	ZIP	**Email**

NYS License # (Required)	**Tel**	**Fax**	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**

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PARENTS/GUARDIANS: READ, COMPLETE, AND SIGN. 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). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner.
   - 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.

OSH Parent Hotline for questions about the Diabetes Medication Administration Form (DMAF): 718-310-2496

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 them 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 them 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 Glucagon if prescribed by their health care provider if my child is temporarily unable to carry and take medicine. **This does not include nasal Glucagon as New York State does not endorse training non-licensed personnel to administer nasal Glucagon at this time.**

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 for Parts A & B**		Date signed _____ /_____ /_____
Parent/Guardian's Address		**Parent/Guardian's Email**	
Telephone Numbers	**Daytime Tel No.**	**Home Tel No.**	**Cell Phone No.**
Alternate Emergency Contact's Name		**Relationship to Student**	**Contact Telephone No.**

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For Office of School Health (OSH) Use Only

OSIS Number:

Received by: Name Date: _____/_____/_____

Reviewed by: Name Date: _____/_____/_____

☐ **504** ☐ **IEP** ☐ **Other** **Referred to School 504 Coordinator** ☐ **Yes** ☐ **No**

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor (for supervised students only)
☐ School Based Health Center

Signature and Title (RN OR SMD):

Date School Notified & Form Sent to DOE Liaison _____/_____/_____

Revisions as per OSH contact with prescribing health care practitioner ☐ **Clarified** ☐ **Modified**

Notes: