# Diabetes Medication Administration Form [Part A]

**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: _____________

OSIS Number: ________________________ DOE District: _____ Grade: ______ Class: __________ Sex: ☐ Male ☐ Female

School (include name number, address, and borough): ______________________________________________________________

**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:_______________________________________

**Orders written will be for Sept. 2022 through Aug. 2023 school year unless checked here: ☐ Current School Year 2021-22 and 2022-2023**

## EMERGENCY ORDERS

**Severe Hypoglycemia Administer Glucagon and CALL 911** *(If more than one option is chosen, school staff will use ONE form of available glucagon unless otherwise directed.)*

| ***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 > 100.5 F ***OR***

☐ Test ketones if bG > _________ mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5 F

► 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 rapid acting insulin.

**Recent A1c:**

Date: ____/____/____ A1c: ____.___ %

**SKILL LEVEL** *(if not complete, will default to nurse-dependent)*

**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 (excluding glucagon) 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** *Insulin is given before food unless noted here* ☐ Give insulin after ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give snack before gym

**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 give pre-gym, no gym ☐ For bG <_______ mg/dl treat hypoglycemia and then give snack ☐ Pre-gym ☐ PRN

☐ **T2DM - no bG monitoring or insulin in school**

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

**Mid-Range Glycemia** *Insulin is given before food unless noted here* ☐ Give insulin after ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give snack before gym if bG <_____mg/dl

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

☐ For bG > ________ mg/dL pre-gym, NO GYM

For bG meter reading "High" use bG of 500 or _______mg/dl

☐ For bG >_________ mg/dl PRN, Give insulin correction dose if > 2 hrs or _______ hrs. since last rapid acting insulin

☐ **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 rapid acting 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 _____ gm carbs from lunch carb 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 8 to 4pm if not specified

**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 rapid acting insulin by syringe or pen and notify parents.

☐ For pump failure, only give correction dose if >______hrs since last rapid acting insulin

**Insulin to Carb Ration (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

**Carb Coverage:**

$\frac{\text{\# gm carb in meal}}{\text{\# gm carb in I:C}} = X$ units insulin

**Correction Dose using ISF:**

$\frac{\text{bG – Target bG}}{\text{insulin ISF}} = X$ units

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.

NYC Health | Office of School Health

# Diabetes Medication Administration Form [Part B]

Provider Medication Order Form | School Year 2022-2023

**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: _________________________ OSIS Number: _______________________

**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 for 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.

| Time | bG | Units Insulin | Other Time ____:______ | bG | Units Insulin |
|---|---|---|---|---|---|
| | Zero – _____ | | | Zero – _____ | |
| ☐ Lunch | _____ – _____ | | ☐ Lunch | _____ – _____ | |
| ☐ Snack | _____ – _____ | | ☐ Snack | _____ – _____ | |
| ☐ Breakfast | _____ – _____ | | ☐ Breakfast | _____ – _____ | |
| ☐ Correction Dose | _____ – _____ | | ☐ Correction Dose | _____ – _____ | |
| | _____ – _____ | | | _____ – _____ | |
| | _____ – _____ | | | _____ – _____ | |

**Optional Orders**

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

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

☐ Use sliding scale for correction AND 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
**Long Acting Insulin Name** ___________________________

**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 Name (Print):___________________________________ First Name (Print): _________________________________________________

Signature: ___________________________________________________________________________________________Date: _____________________

NYS License # (Required): ____________________________ Check one: ☐ MD ☐ DO ☐ NP ☐ PA

Address: ____________________________________________________________________ Email address: ______________________________________

Tel.: ___________________________________ FAX: ___________________________________ Cell Phone:______________________________________

**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**

**INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS**

# Diabetes Medication Administration Form

Provider Medication Order Form | School Year 2022-2023

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

## 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. The Office of School Health (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): 718-786-4933**

## 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.

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**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 (**ATS DBN/Name): ______________________________________________________________ Borough: ________________ District: _____

**Parent/Guardian** Name (Print): _________________________________________ Parent/Guardian's Email: __________________________________

**Parent/Guardian** Signature for Parts A and B: ____________________________________________ Date Signed: ______________

**Parent/Guardian** Address: ___________________________________________________________________________________________

**Telephone Numbers:** Daytime: ___________________________ Home___________________________ Cell Phone: ________________________

**Alternate Emergency Contact:**

Name: ____________________________________ Relationship to Student: ________________ Phone Number:________________________

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## For Office of School Health (OSH) Use Only

**OSIS Number:** ___________________ **Received by -** Name: _____________________________________ Date: ________________

☐ 504 ☐IEP ☐ Other: _________________________ **Reviewed by -** Name: _____________________________________ Date: ________________

**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:**