NYC Health | Office of School Health

Fòm pou bay medikaman kont dyabèt [Pati A]

Fòm pou doktè preskri medikaman | Biwo sante lekòl | Ane lekòl **2021-2022**

DELÈ: 1ye jen. Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la. **Tanpri fakse tout DMAF yo nan 347-396-8932/8945.**

Siyati elèv la: _____ Non: _____ Dat nesans: _____

Nimewo OSIS: _____ Distri DOE: _____ Klas: _____ Salklas: _____ Seks: ☐ Gason ☐ Fi

Lekòl (mete non, nimewo, adrès ak borough): _____

[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. 2021 through Aug. 2022 school year unless checked here: ☐ Current School Year 2021-2022

EMERGENCY ORDERS

Severe Hypoglycemia Administer Glucagon and CALL 911

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

☐ 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 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) ☐ Give insulin after ☐ 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 ☐ Give insulin after ☐ 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

☐ For bG <_____ mg/dl give _____ gm rapid carbs at ☐ Give insulin after ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

Repeat bG testing in 15 or _____ min. If bG still < _____ mg/dl repeat carbs and retesting until bG > _____

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

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

Mid-Range Glycemia 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

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

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.

Delivery Method:

◯ Syringe/Pen ◯ Smart Pen – use pen Suggestions
◯ Pump (Brand) _____

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.

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 pump for hypoglycemia not responding to treatment for _____ min.
☐ Suspend/disconnect pump for gym

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.

Insulin to Carb Ratio (I:C)

Breakfast 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

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS OHS DMAF REV 6/21

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

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Fòm pou doktè preskri medikaman | Biwo sante lekòl | Ane lekòl **2021-2022**

DELÈ: 1ye jen. Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la. **Tanpri fakse tout DMAF yo nan 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 ofcarbs 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 lowerdose 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
Insulin Name _____

Snack Orders

☐ Student may carry and self-administer snack Snack time of day: _____ Type & amount of snack:

Other Orders

HOME MEDICATIONS

☐ None

Medication	Dose	Frequency	Time
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 ak AAP rekòmande pou tout timoun yo dyagnostike ki gen dyabèt pran vaksen grip sezon an chak ane.

FOR PRINT USE ONLY | Confidential Information should not be sent by email.

DELÈ: 1ye jen. Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la. Tanpri fakse tout DMAF yo nan 347-396-8932/8945.

PARAN/RESPONSAB: LI, RANPLI AK SIYEN. LÈ M SIYEN PI BA A, MWEN DAKÒ AVÈK BAGAY SA YO:

1. Mwen dakò pou enfimyè a bay pitit mwen an medikaman yo preskri yo, ak pou enfimyè/estaf yo antrene pou sa a nan lekòl pitit mwen an tcheke nivo sik nan san pitit mwen an epi pou trete nivo sik nan san pitit mwen an dapre rekòmandasyon ak nivo abilite doktè k ap pran swen pitit mwen an detèmine a. Yo ka fè bagay sa yo nan lekòl la oswa pandan pwomnad lekòl la.
2. Mwen dakò tou pou nenpòt ekipman yo bezwen pou yo ka konsève ak itilize medikaman pitit mwen an nan lekòl la.
3. ***Mwen konprann ke:***
   - Mwen sipoze remèt enfimyè lekòl la medikaman, snacks, ekipman yo epi mwen dwe ranplase bagay sa yo lè sa nesesè. OSH rekòmande lansèt sekirite yo ak lòt egui sekirite ak ekipman pou tcheke nivo sik nan san pitit mwen an ak ba li ensilin.
   - **Tout medikaman sou preskripsyon ak tout medikaman "ki vann san preksripsyon (over-the-counter)" fèt pou nèf, kachte nan bwat oswa boutèy orijinal la. M ap bay lekòl la medikaman ki resan, ki pa ekspire pou pitit mwen itilize pandan jounen lekòl la.**
     - 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.
   - 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, mwen otorize OSH pou bay pitit mwen an sèvis sante. Sèvis sa yo ka genyen ladan pami lòt, 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). Lè preskripsyon medikaman sa a ekspire, m ap bay enfimyè lekòl pitit mwen an yon nouvo fòm MAF ke doktè pitit mwen an ap ekri. OSH pa p bezwen siyati m pou l ekri lòt fòm MAF alavni.
   - OSH ak Department of Education (DOE) responsab pou asire yo pitit mwen an ka tcheke nivo sik nan san l.
   - 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 bay sèvis sa yo, pitit mwen an bezwen tou yon Plan akomodasyon pou elèv. Se lekòl la k ap ranpli plan sa a.
   - Nan objektif pou bay pitit mwen an swen oswa tretman, OSH ka gen nenpòt lòt enfòmasyon yo panse ki nesesè sou pwoblèm medikal pitit mwen an, medikaman l ap pran oswa tertman l suiv. OSH ka pran enfòmasyon sa a nan men nenpòt doktè, enfimyè oswa famasyen ki bay pitit mwen an sèvis.

Liy gratis OSH pou paran poze kesyon sou DMAF: 718-310-2496

POU ELÈV KI KA PRAN MEDIKAMN POUKONT YO (ELÈV KI ENDEPANDAN SÈLMAN)

- 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 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. 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 Glucagon sou fòm likid nan bouch ak/oswa glucagon nan nen si se doktè l ki preskri l si pitit mwen an pa kapab pran l 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 (ATS DBN/Non): _____ Borough: _____ Distri: _____

Non paran/responsab (ekri byen klè): _____ Imèl paran/responsab la: _____

Siyati **Paran/Responsab** pou Pati A ak B: _____ Dat fòm lan siyen: _____

Adrès **paran/responsab**: _____

Nimewo telefòn: Lajounen: _____ Lakay: _____ Selilè: _____

Lòt non moun nou ka kontakte lè gen ijans: _____

Non: _____ Relasyon l avèk elèv la: _____ Nimewo telefòn: _____

NYC Health | Office of School Health

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Fòm pou doktè preskri medikaman | Biwo sante lekòl | Ane lekòl 2021-2022

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For Office of School Health (OSH) Use Only / Plas sa a rezève pou Biwo OSH sèlman

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: