Diabetes Medication Administration Form [Part A]

截止日期：6月1日。6月1日之後遞交的表格可能會對新學年的申請程序造成延誤。 請將所有的糖尿病藥物使用表(DMAF) 傳真到347-396-8932/8945。

學生姓氏：_______________ 名字：_______________ 出生日期：（月/日/年） _______________

學生身份（OSIS）號碼：_______________ 教育局學區：_____ 年級：______ 班級：__________ 性別： ☐ 男 ☐ 女

學校（DBN）/學校名稱/ 地址/ 行政區：_______________

健康護理人員填寫以下部分/HEALTH CARE PRACTITIONER COMPLETES BELOW

[Please see 'Provider Guidelines for DMAF Completion']

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other Diagnosis:_______________ Dx Date ____________ Recent A1c Date: _____________ Result: __________ (%)

Orders written will be implemented when submitted and approved. If you wish to start order implementation in September 2024, please check here ☐

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
☐ 0.5 mg SC/IM	☐ 0.5 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 and call 911.

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, has altered mental status or breathing changes and MD not available, CALL 911

☐ Give insulin correction dose if > 2 hrs or ______ hours since last rapid acting insulin.

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 calculates and 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 ☐ Dismissal ☐ PRN

Hypoglycemia *Insulin is given before food unless noted here* ☐ 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 ☐ Dismissal ☐ 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 ☐ Dismissal ☐ 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

****snacks not provided by student's family will be between 15 and 25 g carbohydrates unless otherwise specified in Other Orders***

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 and ☐ check ketones

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 *Optional 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 (time ___ to ____)

Target bG = _____ mg/dl (time ___ to ___)

Insulin Sensitivity Factor (ISF):

1 unit decreases bG by________mg/dl (time________to________)

1 unit decreases bG by________mg/dl (time________to________)

(time will be 7am to 4 pm if not specified)

For Pumps:
- ☐ 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
- ☐ Activity Mode (HCL pumps): Start ___ minutes prior to exercise, to end ____ minutes after exercise is complete (DEFAULT 1 hr prior, during, and 2 hrs following exercise)

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

Carb Coverage:

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

Correction Dose using ISF:

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

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.

Diabetes Medication Administration Form [Part B]

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學生姓氏：________________ 名字：________________ 出生日期：（月/日/年）________________ OSIS號碼：________________

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 ☐ Dismissal ☐ 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 instructions

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.

家長輸入的胰島素劑量 / 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	_____ – _____	
	_____ – _____			_____ – _____	
☐ see attached	_____ – _____			_____ – _____	

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 or NPI # (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

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家長/監護人：通讀、填寫並簽名。我在下面簽名，表示我同意如下：

1. 我同意，根據我子女保健專業人員的說明和所確定的技能水平，護士/校內健康中心（SBHC）可以為我的子女施用我子女的處方藥物，且護士/經訓練的教職工/SBHC提供者可以檢查我子女的血糖，並處理我子女的低血糖問題。這些措施可以在學校場地或在學校組織的外出參觀途中進行。
2. 我也同意，我子女的醫藥所需的任何器材都在學校裏儲存和使用。
3. *我理解：*

- 我必須將我子女的醫藥品、零食、器材及有關用品交給學校護士/SBHC提供者，並必須按需要補充這些醫藥品、零食、器材及有關用品。OSH建議使用安全採血針和其他安全針具及相應用品檢查我子女的血糖水平和補給胰島素。
- 我同意讓我的子女在學校攜帶並儲存他們的504會議所概述的藥物/醫療用品。
- **我給予學校的所有處方和非處方藥物都必須是新的、未曾開封過並裝在其原封瓶子或盒子裏。我將給學校提供我子女在上學日內需使用的當前、未過期的醫藥用品。**
    - 處方藥物必須在其盒子或瓶子上有原裝藥房標籤。標籤必須包括：1）我子女的姓名；2）藥房名稱和電話號碼；3）我子女的保健專業人員姓名；4）日期；5）重配次數；6）藥物名稱；7）劑量；8）何時用藥；9）如何用藥；10）任何其他說明。
- 如果我子女的藥物發生任何變化或者保健專業人員的說明有任何變化，我必須**立即**告知學校護士/SBHC提供者。
- 涉及到給我子女提供上述健康服務的學校健康辦公室（OSH）及其代理人員依賴於本表資訊的精確度。
- 我在這一「藥物施用表」（MAF）上簽名，表示授權學校健康辦公室（OSH）為我子女提供糖尿病相關的健康服務。這些服務可以包括（但不限於）由一名OSH辦公室保健專業人員或護士所執行的臨床評估或體檢。
- 這份MAF表的醫療執行手續的過期時間是我子女的學年結束（這可能包括暑期班）或者當我交給學校護士/SBHC提供者一份新的MAF（取兩者中較早的那個時間）。當這份醫療手續執行要求過期時,我將交給我子女的學校護士/SBHC提供者一份新的由我子女的保健專業人員出具的MAF。
- OSH和教育局（DOE）確保我的子女能夠安全地測試其血糖。
- 這份表格表明我對本表所說明的糖尿病服務的同意和要求，並且可以直接傳送給OSH。這並非OSH提供所要求的服務的協議。如果OSH決定提供這些服務，我子女可能還需要一份「第504款特別照顧計劃」（Section 504 Accommodation Plan）。這份計劃將由學校填寫。
- 爲著給我子女提供護理或治療的目的，OSH可以獲取該辦公室認爲有關我子女的醫療狀況、藥物和治療而需要的任何其他資訊。OSH可以向任何為我子女提供健康服務的保健專業人員、護士或藥劑師索取該資訊。

註：最好是您在學校外出參觀的日子和在校外進行學校活動時給子女帶上藥物和器材。

用於詢問有關糖尿病藥物施用表（DMAF）的問題的OSH家長熱線：718-786-4933

自己用藥（僅適用於能自己獨立用藥的學生）：

- 我證明/確認，我子女已得到完全的訓練並能夠自行用藥。我同意，我的子女在學校裏以及在學校參觀旅行時自己攜帶、儲存並施用本表格上所開具的藥物。我負責根據上述說明把瓶子或盒子裏的藥物交給我子女。我也負責監督我子女在學校裏的藥物使用情況及其對這一藥物使用所導致的任何後果。學校護士將確認我子女擁有攜帶和自行用藥的能力。我也同意交給學校「備用」藥物（裝在清楚地標示的盒子或瓶子裏）。
- 我同意，如果我的子女暫時無法攜帶藥品和用藥，而如果醫護人員開具處方，學校護士或受過訓練的學校員工可給我的子女施用可注射胰高血糖素和/或鼻噴用胰高血糖素。

學生姓氏：＿＿＿＿＿＿ 名字：＿＿＿＿＿＿ 中間名首字母：＿＿ 出生日期：（月/日/年）＿＿＿＿＿＿

學校（ATS DBN/名稱）：＿＿＿＿＿＿＿＿＿＿ 行政區：＿＿＿＿＿＿ 學區：＿＿

家長/監護人姓名（用英文清楚書寫）：＿＿＿＿＿＿＿＿ 家長/監護人電子郵箱：＿＿＿＿＿＿＿＿

家長/監護人簽名（A和B部分）：＿＿＿＿＿＿＿＿ 簽名日期：（月/日/年）＿＿＿＿＿＿

家長/監護人地址：＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

電話號碼：　日間：＿＿＿＿＿＿ 住宅：＿＿＿＿＿＿ 手機：＿＿＿＿＿＿

其他緊急聯絡人：

姓名：＿＿＿＿＿＿＿＿ 與學生的關係：＿＿＿＿＿＿ 電話號碼：＿＿＿＿＿＿

僅供學校健康辦公室（OSH）工作人員填寫 / 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: