

**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	<input type="checkbox"/> Male <input type="checkbox"/> 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    
 **Recent A1C** \_\_\_\_\_

Other Diagnosis: \_\_\_\_\_    
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**

<p><b>Severe Hypoglycemia Administer Glucagon and CALL 911</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:12.5%;">Glucagon</th> <th style="width:12.5%;">GVOKE</th> <th style="width:12.5%;">Baqsimi</th> <th style="width:12.5%;">Zegalogue</th> </tr> <tr> <td><input type="checkbox"/> 1 mg</td> <td><input type="checkbox"/> 1 mg</td> <td><input type="checkbox"/> 3 mg</td> <td><input type="checkbox"/> 0.6 mg SC</td> </tr> <tr> <td><input type="checkbox"/> _____mg SC/IM</td> <td><input type="checkbox"/> _____mg SC/IM</td> <td>Intranasal</td> <td>may repeat in 15 min if needed</td> </tr> </table> <p>Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration.</p>	Glucagon	GVOKE	Baqsimi	Zegalogue	<input type="checkbox"/> 1 mg	<input type="checkbox"/> 1 mg	<input type="checkbox"/> 3 mg	<input type="checkbox"/> 0.6 mg SC	<input type="checkbox"/> _____mg SC/IM	<input type="checkbox"/> _____mg SC/IM	Intranasal	may repeat in 15 min if needed	<p><b>Risk for Ketones or Diabetic Ketoacidosis (DKA)</b></p> <p><input type="checkbox"/> Test ketones if bG &gt; _____ mg/dl or if vomiting, or fever &gt; 100.5F for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever &gt; 100.5F</p> <p><input type="checkbox"/> Test ketones if bG &gt; _____ mg/dl or if vomiting or fever &gt; 100.5F</p> <p>▶ If small or trace give water; re-test ketones &amp; bG in 2 hrs or _____ hrs</p> <p>▶ If ketones are moderate or large, give water; Call parent and Endocrinologist <input type="checkbox"/> NO GYM</p> <p>▶ If ketones and vomiting, unable to take PO and MD not available, CALL 911</p> <p><input type="checkbox"/> Give insulin correction dose if &gt; 2 hrs or _____ hours since last insulin.</p>
Glucagon	GVOKE	Baqsimi	Zegalogue										
<input type="checkbox"/> 1 mg	<input type="checkbox"/> 1 mg	<input type="checkbox"/> 3 mg	<input type="checkbox"/> 0.6 mg SC										
<input type="checkbox"/> _____mg SC/IM	<input type="checkbox"/> _____mg SC/IM	Intranasal	may repeat in 15 min if needed										

**SKILL LEVEL**

<p><b>Blood Glucose (bG) Monitoring Skill Level</b></p> <input type="checkbox"/> Nurse / adult must check bG. <input type="checkbox"/> Student to check bG with adult supervision. <input type="checkbox"/> Student may check bG without supervision.	<p><b>Insulin Administration Skill Level</b></p> <input type="checkbox"/> Nurse-Dependent Student: nurse must administer medication <input type="checkbox"/> Supervised student: student self administers, under adult supervision	<input type="checkbox"/> Independent Student Self-carry / Self-administer ( <i>MUST Initial attestation</i> ) I attest that the independent student demonstrated the ability to self-administer the prescribed medication effectively during school, field trips and school sponsored events  <div style="text-align: right;">Provider Initials _____</div>
---	---	---

**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      T2DM - no bG monitoring or insulin in school

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

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

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**

<p><b>Insulin Name*</b> _____</p> <p><small>*May substitute Novolog with Humalog/Admelog</small></p> <p><input type="checkbox"/> No Insulin in School     <input type="checkbox"/> No Insulin at Snack</p> <p><b>Delivery Method</b></p> <p><input type="checkbox"/> Syringe/Pen     <input type="checkbox"/> Smart Pen – use pen Suggestions</p> <p><input type="checkbox"/> Pump (Brand) _____</p>	<p><b>Insulin Calculation Method</b></p> <p><input type="checkbox"/> Carb coverage ONLY at <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack</p> <p><input type="checkbox"/> Correction dose ONLY at <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack</p> <p><input type="checkbox"/> Carb coverage plus correction dose when bG &gt; Target AND at least 2 hrs or _____ hrs. since last insulin at <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack</p> <p><b>Correction dose calculated using</b> <input type="checkbox"/> ISF or <input type="checkbox"/> Sliding Scale</p> <p><input type="checkbox"/> Fixed Dose (see Other Orders) <input type="checkbox"/> Sliding Scale (See Part B)</p> <p><input type="checkbox"/> If gym/recess is immediately following lunch, subtract _____ carbs from lunch calculation.</p> <p><b>Round DOWN</b> 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. <b>Round DOWN</b> to nearest 0.1 unit for pumps, unless following pump recommendations or PCP/Endocrinologist orders.</p>	<p><b>Insulin Calculation Directions</b> (give number, not range)</p> <p style="text-align: center;">Target bG = _____ mg/dl</p> <p><b>Insulin Sensitivity Factor (ISF)</b></p> <p>1 unit decreases bG by _____ mg/dl (time _____ to _____)</p> <p>1 unit decreases bG by _____ mg/dl (time _____ to _____)</p> <p><i>If only one ISF, time will be 8am to 4pm if not specified.</i></p> <p><b>Insulin to Carb Ratio (I:C)</b></p> <p>Bkfst OR time _____ to _____</p> <p>1 unit per _____ gms carbs</p> <p>Snack OR time _____ to _____</p> <p>1 unit per _____ gms carbs</p> <p>Lunch OR time _____ to _____</p> <p>1 unit per _____ gms carbs</p> <p>Lunch followed by gym _____ to _____</p> <p>1 unit per _____ gms carbs</p>
<p><b>Carb Coverage</b>     <b>Correction Dose using ISF</b></p> <p># gm carb in meal = X units insulin     bG – Target bG = X units insulin</p> <p># gm carb in I:C</p>	<p><b>For Pumps—Basal Rate In School</b></p> <p>_____ : _____ am/pm to _____ : _____ am/pm _____ units/hr</p> <p>_____ : _____ am/pm to _____ : _____ am/pm _____ units/hr</p> <p>_____ : _____ am/pm to _____ : _____ am/pm _____ units/hr</p> <p><input type="checkbox"/> Student on FDA approved hybrid closed loop pump-basal rate variable per pump.     <input type="checkbox"/> Suspend/disconnect pump for gym</p> <p><input type="checkbox"/> Suspend pump for hypoglycemia not responding to treatment for _____ min.</p>	<p><b>Additional Pump Instructions</b></p> <p><input type="checkbox"/> Follow pump recommendations for bolus dose (if not using pump recommendations, will round down to nearest 0.1 unit)</p> <p><input type="checkbox"/> For bG &gt; _____ mg/dl that has not decreased in _____ hrs after correction, consider pump failure and notify parents.</p> <p><input type="checkbox"/> For suspected pump failure: SUSPEND pump, give insulin by syringe or pen, and notify parents.</p> <p><input type="checkbox"/> For pump failure, only give correction dose if &gt; _____ hrs since last insulin.</p>

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

OHS DMAF REV 4/21

**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 #
-------------------	------------	--	--------

**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
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**

**OPTIONAL ORDERS**

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.

Round insulin dosing to nearest whole unit: 0.51-1.50u rounds to 1.00u.  Use sliding scale for correction AND at meals ADD:

	bG	Units Insulin	Other Time	bG	Units Insulin
<input type="checkbox"/> Lunch	Zero —		:	Zero —	
<input type="checkbox"/> Snack					
<input type="checkbox"/> Breakfast					
<input type="checkbox"/> Correction Dose					
			<input type="checkbox"/> Lunch		
			<input type="checkbox"/> Snack		
			<input type="checkbox"/> Breakfast		
			<input type="checkbox"/> Correction Dose		

Round insulin dosing to nearest half unit: \_\_\_\_\_ units for lunch; 0.26-0.75u rounds to 0.50 u (must have half unit syringe/pen). \_\_\_\_\_ units for snack; \_\_\_\_\_ units for breakfast

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

Long acting insulin given in school Insulin Name

Dose \_\_\_\_\_ units

Time \_\_\_\_\_ or  Lunch

**SNACK ORDERS**

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

AM / PM

**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 <input type="checkbox"/> check one <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> 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.
--------------------------	-----	-----	---

**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. 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	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.

**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: