

DUE: June 1st. Forms submitted after June 1st may delay processing for new school year.

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']

<input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Non-Type 1/Type 2 Diabetes <input type="checkbox"/> Other Diagnosis: _____	Recent A1c Date _____ / _____ / _____ Result _____ %
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Orders written will be for Sept '22 through Aug '23 school year unless checked here **Current School Year 2021-22 and 2022-23**

EMERGENCY ORDERS

<p align="center">Severe Hypoglycemia Administer Glucagon and CALL 911</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:15%;">Glucagon</th> <th style="width:15%;">GVOKE</th> <th style="width:15%;">Baqsimi</th> <th style="width:15%;">Zegalogue</th> </tr> <tr> <td><input type="checkbox"/> 1 mg <input type="checkbox"/> _____ mg SC/IM</td> <td><input type="checkbox"/> 1 mg <input type="checkbox"/> _____ mg SC/IM</td> <td><input type="checkbox"/> 3 mg Intranasal</td> <td><input type="checkbox"/> 0.6 mg SC 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. If more than one option is chosen, school staff will use ONE form of available glucagon unless otherwise directed.</p>	Glucagon	GVOKE	Baqsimi	Zegalogue	<input type="checkbox"/> 1 mg <input type="checkbox"/> _____ mg SC/IM	<input type="checkbox"/> 1 mg <input type="checkbox"/> _____ mg SC/IM	<input type="checkbox"/> 3 mg Intranasal	<input type="checkbox"/> 0.6 mg SC May repeat in 15 min if needed	<p align="center">Risk for Ketones or Diabetic Ketoacidosis (DKA)</p> <input type="checkbox"/> Test ketones if bG > _____ mg/dl or if vomiting, or fever > 100.5 F OR <input type="checkbox"/> 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 <input type="checkbox"/> NO GYM ➤ If ketones and vomiting, unable to take PO and MD not available, CALL 911 <input type="checkbox"/> Give insulin correction dose if > 2 hrs or _____ hours since last rapid acting insulin.
Glucagon	GVOKE	Baqsimi	Zegalogue						
<input type="checkbox"/> 1 mg <input type="checkbox"/> _____ mg SC/IM	<input type="checkbox"/> 1 mg <input type="checkbox"/> _____ mg SC/IM	<input type="checkbox"/> 3 mg Intranasal	<input type="checkbox"/> 0.6 mg SC May repeat in 15 min if needed						

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

Blood Glucose (bG) Monitoring Skill Level <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.	Insulin Administration Skill Level <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 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 bG in school (must match times for treatment and/or insulin) <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Gym <input type="checkbox"/> PRN	
Hypoglycemia <i>Insulin is given before food unless noted here</i> <input type="checkbox"/> Give insulin after <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Give Snack before gym <i>Check all boxes needed. Must include at least one treatment plan.</i> <input type="checkbox"/> For bG < _____ mg/dl give _____ gm rapid carbs at <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Gym <input type="checkbox"/> PRN Repeat bG testing in 15 min or _____ min. If bG still < _____ mg/dl repeat carbs and retesting until bG > _____ mg/dl <input type="checkbox"/> For bG < _____ mg/dl give _____ gm rapid carbs at <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Gym <input type="checkbox"/> PRN Repeat bG testing in 15 min or _____ min. If bG still < _____ mg/dl repeat carbs and retesting until bG > _____ mg/dl <input type="checkbox"/> For bG < _____ mg/dl pre-gym, no gym <input type="checkbox"/> For bG < _____ mg/dl treat hypoglycemia and then give snack <input type="checkbox"/> Pre-gym <input type="checkbox"/> PRN	<input type="checkbox"/> T2DM – no bG monitoring or insulin in school 15 gm rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4oz. juice

Mid-Range Glycemia	<i>Insulin is given before food unless noted here</i> <input type="checkbox"/> Give insulin after <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Give Snack before gym if bG < _____ mg/dl
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Hyperglycemia	<i>Insulin is given before food unless noted here</i> <input type="checkbox"/> Give insulin after <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack
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<input type="checkbox"/> For bG > _____ mg/dl pre-gym, NO GYM <input type="checkbox"/> For bG > _____ mg/dl PRN, Give insulin correction dose if > 2 hrs or _____ hrs. since last rapid acting insulin	For bG meter reading "High" use bG of 500 or _____ mg/dl
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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 _____ <i>*May substitute Novolog with Humalog/Admelog</i> <input type="checkbox"/> No Insulin in school <input type="checkbox"/> No insulin at Snack Delivery Method <input type="checkbox"/> Syringe/Pen <input type="checkbox"/> Smart Pen – use pen suggestions <input type="checkbox"/> Pump (Brand) _____	Insulin Calculation Method: <input type="checkbox"/> Carb coverage ONLY at: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Correction dose ONLY at: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Carb coverage plus correction dose when bG > Target AND at least 2 hrs or _____ hrs since last rapid acting insulin at <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack Correction dose calculated using: <input type="checkbox"/> ISF or <input type="checkbox"/> Sliding Scale <input type="checkbox"/> Fixed Dose (see Other Orders) <input type="checkbox"/> Sliding Scale (See Part B) <input type="checkbox"/> 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 _____) <i>If only one ISF, time will be 8am to 4pm if not specified</i>
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 <input type="checkbox"/> Student on FDA approved hybrid closed loop pump-basal rate variable per pump. <input type="checkbox"/> Suspend/disconnect pump for gym <input type="checkbox"/> Suspend pump for hypoglycemia not responding to treatment for _____ min	Additional Pump Instructions: <input type="checkbox"/> Follow pump recommendations for bolus dose (if not using pump recommendations, will round down to nearest 0.1 unit) <input type="checkbox"/> For bG > _____ mg/dl that has not decreased in _____ hours after correction, consider pump failure and notify parents. <input type="checkbox"/> For suspected pump failure: SUSPEND pump, give rapid acting insulin by syringe or pen, and notify parents. <input type="checkbox"/> For pump failure, only give correction dose if > _____ hrs since last rapid acting insulin	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
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.



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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

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

2. 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 -		<input type="checkbox"/> Lunch	Zero -	
-		<input type="checkbox"/> Snack	-	
-		<input type="checkbox"/> Breakfast	-	
-		<input type="checkbox"/> 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 0.50u (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 – Insulin Name: _____
 Dose: _____ units Time _____ or Lunch

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 <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.

PARENTS AND 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 their 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 their 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.

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 Tel 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

Empty box for notes