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:

Recent A1c ____________________________ Date ____________________________ Result __________________

Orders written will be implemented when submitted and approved. If you wish to delay orders for September 2023 please check here ☐

EMERGENCY ORDERS

Syringe/Pen ☐

No Insulin in school ☐

For bG < mg/dl give gm rapid carbs at ☐

For bG < mg/dl give gm rapid carbs at ☐

Pump-basal rate variable per pump.

*May substitute Novolog with Humalog/Admelog

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 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)

☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

Hypoglycemia

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

Repeat bg testing in 15 min or min. If bg still < mg/dl repeat carbs and retesing until bg > mg/dl

☐ For bg < mg/dl give gm rapid carbs at ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym

Repeat bg testing in 15 min or min. If bg still < mg/dl repeat carbs and retesing until bg > mg/dl

For bg < mg/dl pre-gym, no gym ☐ For bg < mg/dl give hypoglycemia and then give snack ☐ Pre-gym ☐ PRN

Mid-Range Glycemia

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

For bg < mg/dl ☐ Give insulin before snack if bg < mg/dl

For bg > mg/dl PRN, give insulin correction dose if > 2 hrs or hrs. since last rapid acting insulin

For bg or Sensor Glucose (sG) before dismissal

Give correction dose pre-meal and carb coverage after meal

For bg or sG values < mg/dl treat for hypoglycemia if needed, and give gm carb snack before dismissed

For bg or sG 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) ________________

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 for minutes duration (DEFAULT 1 hr prior, during, and 2 hrs following exercise)

Carb Coverage: 6 gms carb in meal = X units insulin

Correction Dose using ISF:

Round DOWN insulin dose to closest 0.5 unit for syrup/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.

Insulin Sensitivity Factor (ISF):

1 unit decreases bg by mg/dl

Insulin to Carb Ratio (I/C):

Bikfast 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

Insulin Calculation Directions: (give number, not range)

If only one given, time will be 7am to 4pm if not specified

Target bg = mg/dl (time to )

Target bg = mg/dl (time to )

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 bg is consistently below 70 mg/dl, subtract _gms carbs from lunch carb calculation.

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

T-35514 (Arabic)
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). You must include name and model of the CGM in use.

Name and Model of CGM:

For CGM used for insuling: 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

<table>
<thead>
<tr>
<th>CGM reading</th>
<th>Arrows</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>sg &lt; 60 mg/dl</td>
<td>Any arrows</td>
<td>Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still &lt; 70 mg/dl check bG.</td>
</tr>
<tr>
<td>sg 60-70 mg/dl</td>
<td>and ↓, ↓↓ or →</td>
<td>Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still &lt; 70 mg/dl check bG.</td>
</tr>
<tr>
<td>sg 60-70 mg/dl</td>
<td>and ↑, ↑↑ or ↓</td>
<td>If symptomatic, treat hypoglycemia per bG hypoglycemia plan; if not symptomatic, recheck in 15-20 minutes. If still &lt; 70 mg/dl check bG.</td>
</tr>
<tr>
<td>sg &gt; 70 mg/dl</td>
<td>Any arrows</td>
<td>Follow bG DMAF orders for insulin dosing</td>
</tr>
<tr>
<td>sg &lt; 120 mg/dl pre-gym or recess</td>
<td>and ↓, ↓↓</td>
<td>Give 15 gms uncovered carbs. If gym or recess is immediately after lunch, subtract 15 gms of carbs from lunch carb calculation.</td>
</tr>
<tr>
<td>sg &gt; 250</td>
<td>Any arrows</td>
<td>Follow bG DMAF orders for treatment and insulin dosing</td>
</tr>
</tbody>
</table>

☐ 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.

<table>
<thead>
<tr>
<th>Route</th>
<th>Dose</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lunch</td>
<td>0.50u</td>
<td>0.50u</td>
</tr>
<tr>
<td>Snack</td>
<td>0.25u</td>
<td>0.25u</td>
</tr>
<tr>
<td>Breakfast</td>
<td>0.75u</td>
<td>0.75u</td>
</tr>
<tr>
<td>Correction Dose</td>
<td>1.00u</td>
<td>1.00u</td>
</tr>
</tbody>
</table>

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:

Each units for lunch:
Each units for snack:
Each units for breakfast
(scaling 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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Time</th>
<th>House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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 ☐ MD ☐ DO ☐ NP ☐ 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.
لا يوجد نص يمكن قراءته بشكل طبيعي من الصورة المقدمة.
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
☐ School Based Health Center
☐ OSH Public Health Advisor (for supervised students only)

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