NYC Health Office of School Health

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

Diabetes Medication Administration Form [Part A]

Provider Medication Order Form | School Year 2024-25

Please fax all DMAFs to 347-396-8932/8945

Student Last Name:	**First Name:**	**Date of Birth:**	☐ Male ☐ 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

☐ 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

Glucagon	GVOKE	Baqsimi	Zegalogue
☐ 1 mg ☐ 0.5 mg SC/IM	☐ 1 mg ☐ 0.5 mg SC/IM	☐ 3 mg Intranasal	☐ 0.6 mg SC 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. If more than one option is chosen, school staff will use ONE form of available glucagon unless otherwise directed.

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 a nd 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 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 ☐ Dismissal ☐ PRN

Hypoglycemia *Insulin is given before food unless noted here* Give insulin after ☐ 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 min 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 min or_____min. If bG still <_____mg/dl repeat carbs and retesting until bG >_____mg/dl

☐ For bG < _____mg/dl pre-gym, no gym ☐ For bG < _____mg/dl treat hypoglycemia and then give snack* ☐ Pre-gym ☐ PRN

snacks not provided by students family will be between 15 and 25 g carbohydrates unless otherwise specified in Other Orders

☐ **T2DM** – no bG monitoring or insulin in school

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

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) 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 Sensitivity Factor (ISF):

1 unit decreases bG by _____mg/dl

(time _____to_____)

1 unit decreases bG by _____mg/dl

(time_____to_____)

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 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

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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Diabetes Medication Administration Form [Part B]

Provider Medication Order Form | School Year 2024-25

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Student Last Name:	**First Name:**	**Date of Birth:**	**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). You must include name and model of the CGM in use.

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 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

☐ See attached

bG	**Units Insulin**	**Other Time ____:____**	**bG**	**Units Insulin**
Zero -		☐ Lunch	Zero -	
-		☐ Snack	-	
-		☐ Breakfast	-	
-		☐ 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 ☐ MD ☐ DO ☐ NP ☐ PA		

Address STREET	CITY/STATE	ZIP	**Email**

NPI# or NYS License # (Required)	Tel	Fax	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**

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PARENTS AND GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to the nurse/school based health center (SBHC) provider giving my child's prescribed medicine, and the nurse/trained staff/SBHC provider 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/SBHC provider 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.
   - I consent to my child carrying and storing their medication/supplies in school and on trips as outlined in their 504 meeting.
   - **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/SBHC provider 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. Theseservices 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/SBHC provider a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse/ SBHC provider a new MAF written by my child's health care practitioner.
   - OSH and the Department of Education (DOE) make 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, and may be sent directly to OSH. 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.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

OSH Parent Hotline for questions about the Diabetes Medication Administration Form (DMAF): 718-786-4933

FOR SELF-ADMINISTRATION OF MEDICINE AND/OR PROCEDURES (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine and/or perform procedures on their own. I consent to my child carrying, storing and giving them the medicine prescribed on this form in school and on trips. 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 or SBHC providers 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.

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.**

Confidential Information should not be sent by email.

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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

Confidential Information should not be sent by email.