

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	Recent A1c
<input type="checkbox"/> Other Diagnosis: _____ Dx Date: ____/____/____	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				Risk for Ketones or Diabetic Ketoacidosis (DKA)	
Glucagon	GVOKE	Baqsimi	Zegalogue	<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, has altered mental status or breathing changes and MD not available, CALL 911 <input type="checkbox"/> Give insulin correction dose if > 2 hrs or _____ hours since last rapid acting insulin.	
<input type="checkbox"/> 1 mg <input type="checkbox"/> 0.5 mg SC/IM	<input type="checkbox"/> 1 mg <input type="checkbox"/> 0.5 mg SC/IM	<input type="checkbox"/> 3 mg Intranasal	<input type="checkbox"/> 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.					

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 calculates and self-administers, under adult supervision	<input type="checkbox"/> 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 _____
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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"/> Dismissal <input type="checkbox"/> PRN	
Hypoglycemia	Insulin is given before food unless noted here Give insulin after <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Give Snack* before gym
Check all boxes needed. Must include at least one treatment plan.	
<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"/> Dismissal <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"/> T2DM – no bG monitoring or insulin in school 15 gm rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4oz. juice
<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"/> Dismissal <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 <i>*snacks not provided by students family will be between 15 and 25 g carbohydrates unless otherwise specified in Other Orders</i>	
Mid-Range Glycemia	Insulin is given before food unless noted here 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
Hyperglycemia	Insulin is given before food unless noted here Give insulin after <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack
<input type="checkbox"/> For bG > _____ mg/dl pre-gym, no gym and <input type="checkbox"/> check ketones For bG meter reading "High" use bG of 500 or _____ mg/dl <input type="checkbox"/> For bG > _____ mg/dl PRN, Give insulin correction dose if > 2 hrs or _____ hrs. since last rapid acting insulin <input type="checkbox"/> Check bG or Sensor Glucose (sG) before dismissal <input type="checkbox"/> Give correction dose pre-meal and carb coverage after meal <input type="checkbox"/> For sG or bG values < _____ mg/dl treat for hypoglycemia if needed, and give _____ gm carb snack before dismissed <input type="checkbox"/> 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	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 Optional 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) 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 _____)
Delivery Method <input type="checkbox"/> Syringe/Pen <input type="checkbox"/> Smart Pen – use pen suggestions <input type="checkbox"/> Pump (Brand) _____	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 Sensitivity Factor (ISF): 1 unit decreases bG by _____ mg/dl (time _____ to _____) 1 unit decreases bG by _____ mg/dl (time _____ to _____)
For Pumps: <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 <input type="checkbox"/> 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)	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	Insulin to Carb Ratio (I:C): Bkfst 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
Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have 1/2 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). 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]

Table with 3 columns: CGM reading, Arrows, Action. Rows include sG < 60 mg/dl, sG 60-70 mg/dl, sG > 70 mg/dl, sG <= 120 mg/dl pre-gym or recess, sG >= 250.

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

Table with 5 columns: bG, Units Insulin, Other Time, bG, Units Insulin. Rows for Lunch, 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

Table with 5 columns: Medication, Dose, Frequency, Time, Route. Rows for 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.



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. 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/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.



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

Large empty rectangular box for notes.