NYC OFFICE OF SCHOOL HEALTH – DIABETES MEDICATION ADMINISTRATION FORM — SCHOOL YEAR 2013-2014

Student Name				Sex ☐ Female ☐ Male	Date of Birth __ __ / __ __ / __ __ __ __ (Month / Day / Year)
ID Number __ __ __ __ __ __ __ __ __	DOE District __ __ __	School	Grade __ __	Class	Borough
School Address			Most Recent A1C Date ____/____/____ Result _____		

EMERGENCY SITUATIONS

Severe Hypoglycemia

☐ **Give Glucagon AND CALL 911**

PRN for unconsciousness, unresponsiveness, seizure, or inability to swallow EVEN if the bG is unknown. Turn onto left side to prevent aspiration.

☐ 1 mg SC/IM

☐ ___ mg SC/IM

Risk for Diabetic Ketoacidosis (DKA)

☐ **Ketones:** Test ketones if hyperglycemic*, vomiting, or fever ≥100.5

If small or trace, give water. Re-test ketones and bG in _____ hours

If initial or retest ketones are moderate or large, give water and:

☐ Call parent and/or MD ☐ No Gym

☐ If vomiting, unable to take PO, and MD not available, **CALL 911.**

☐ **Give insulin, if ordered below**

Diagnosis ☐ Type 1 Diabetes ICD9: _____ ☐ Type 2 Diabetes ICD9: _____

☐ Other: _____

Blood Glucose Monitoring and Insulin Orders

Student:

☐ May check bG without supervision ☐ May give insulin without supervision

☐ May check bG with supervision ☐ May give insulin with supervision

☐ Must have school personnel check bG ☐ Must have school nurse give insulin

	☐ Lunch	☐ Snack	☐ Gym	☐ PRN
Hypoglycemia	**For bG< _____ mg/dL** Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; if bG < _____, repeat carbs and re-check until bG > _____. THEN ☐ **Give insulin, BEFORE Lunch** ☐ **Give insulin AFTER Lunch**	**For bG< _____ mg/dL** Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; if bG < _____, repeat carbs and re-check until bG > _____. THEN ☐ **Give insulin BEFORE Snack** ☐ **Give insulin AFTER Snack**	**For bG< _____ mg/dL** Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; if bG < _____, repeat carbs and re-check until bG > _____. ☐ If initial bG < ____, **No Gym** ☐ Give Snack **AFTER** treatment **THEN** send student to Gym	**For bG< _____ mg/dL** Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; if bG < _____, repeat carbs and re-check until bG > _____. ☐ Give Snack after treating Hypoglycemia
Between Hypo- and Hyperglycemia	☐ **Give insulin BEFORE Lunch** ☐ **Give insulin AFTER Lunch**	☐ **Give insulin BEFORE Snack** ☐ **Give insulin AFTER Snack**	☐ Give Snack **BEFORE** Gym ☐ Send to Gym	
Hyperglycemia* bG > _____	☐ **Test ketones if bG > _____ mg/dL** Treat as per Risk for DKA above ☐ **Give insulin BEFORE Lunch** ☐ **Give insulin AFTER Lunch**	☐ **Test ketones if bG > _____ mg/dL** Treat as per Risk for DKA above ☐ **Give insulin BEFORE Snack** ☐ **Give insulin AFTER Snack**	☐ **Test ketones if bG > _____ mg/dL** Treat as per Risk for DKA above For bG> _____ mg/dL **No Gym** For bG> _____ mg/dL AND at least ____ hours since last insulin, **give insulin**	☐ **Test ketones if bG > _____ mg/dL** Treat as per Risk for DKA above For bG> _____ mg/dL **No Gym** For bG> _____ mg/dL AND at least ____ hours since last insulin, **give insulin**
Carb Coverage Insulin Instructions	☐ Carb coverage ONLY ☐ Carb coverage PLUS Correction Dose when bG > Target bG	☐ Carb coverage ONLY ☐ Carb coverage PLUS Correction Dose when bG > Target bG		

INSULIN ORDERS (CHECK ONE BOX ONLY)

☐ Carb Coverage (plus Correction Dose if ordered above) ☐ Sliding Scale ☐ Carb Coverage plus Sliding Scale for Correction ☐ No Insulin at School Glucose Monitorning ONLY

☐ **Syringe/Pen**	**Name of Insulin**			☐ **Insulin Pump** *(Brand & Model)*	
Target (Single #) bG = _____ mg/dL	**Sensitivity Factor (Correction)** 1 unit will decrease bG by _____mg/dL	**Insulin:Carb Ratio:** (I:C)	For LUNCH 1:_____ gms / For SNACK 1:_____ gms	**Basal Rate(s):** In School _____ units/hour ☐ Gym _____%	Temporary basal rate for _____ hours ☐ Disconnect Pump for gym
Target (Single #) bG = _____ mg/dL	**Sensitivity Factor (Correction)** 1 unit will decrease bG by _____mg/dL	**Insulin:Carb Ratio:** (I:C)	For LUNCH 1:_____ gms / For SNACK 1:_____ gms	**Basal Rate(s):** In School _____ units/hour ☐ Gym _____%	Temporary basal rate for _____ hours ☐ Disconnect Pump for gym

Round DOWN the insulin dose to the closest 0.5 units for syringe/pen unless otherwise instructed by the PCP

Carb Coverage = $\frac{\text{\# gms carb in meal}}{\text{\# gms carb in I:C}}$ = _____ units insulin **Correction Dose** = $\frac{\text{bG – Target bG}}{\text{Sensitivity Factor}}$ = _____ units insulin

Example: Carb Coverage plus Correction Dose

Current bG = 250 Target bG=150 Sensitivity Factor = 100 Insulin:Carb ratio = 1:20 Lunch carbs = 60 gms

Carb Coverage: $\frac{\text{60 gms carb}}{\text{20}}$ = 3 units **PLUS Correction Dose:** $\frac{\text{250-150}}{\text{100}}$ = **1 unit TOTAL DOSE: 3+1=4 units**

For Pump:

☐ Follow Pump recommendation for bolus dose [If not using Pump recommendation, round DOWN the dose down to nearest 0.1 unit]

☐ For bG > _____ mg/dL that has not decreased _____ hours after correction consider pump failure. Notify parent.

☐ For suspected pump failure: DISCONNECT pump and give insulin by syringe or pen

SLIDING SCALE

Name of Insulin _____

Please do NOT overlap ranges (e.g. 100-200, 200-300, etc). If ranges overlap, the lower dose will be given.

☐ Pre lunch	bG Range	Insulin Units	☐ Other time	bG Range	Insulin Units
	_____	_____	_____	_____	_____
	_____	_____		_____	_____
	_____	_____		_____	_____

SNACK:

Time of day: _____

Type & Amount:

☐ Student may carry and self administer snacks

HOME MEDICATIONS

Insulin *(Dose, Frequency, and Time)*

Oral Medications *(Dose, Frequency, and Time)*

OTHER DIABETES ORDERS

Health Care Practitioner Name *(Please Print)* FIRST NAME / LAST NAME		HCP Signature		**For DOHMH USE: Revisions per consult with Prescriber:**
Address		Medicaid No.	NPI No.	
Tel. No.	Fax. No.	NYS Lic. No. **(Required)**	Date __ __ / __ __ / __ __	

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

MONITORING BLOOD SUGAR, MEDICATION AND DIETARY NEEDS: PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION 2013–2014

I hereby authorize: (1) the monitoring of my child's blood sugar, (2) the provision of medically prescribed treatment and/or (3) the treatment of hypoglycemic episodes on school premises, in accordance with the attached instructions of his/her physician. I understand that I must furnish all necessary snacks, equipment and supplies and that I must immediately advise the principal and/or his/her designee(s), especially the school nurse, of any change in the prescription or instructions stated above.

I understand that this Authorization is only valid until the earlier of: (1) June 27, 2014; (This prescription may be extended through August if the student is attending a New York City Department of Education (the" Department") sponsored summer instruction program); or (2) such time that I deliver to the principal, his/her designee(s) and school nurse a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed monitoring and treatment.

I recognize that the New York City Department of Education (the "Department"), its agents and the Department of Health and Mental Hygiene ("DOHMH") has a responsibility to ensure a safe environment in the medical room and anywhere else where my child may test his or her blood sugar. I will make every effort to provide the school with safety lancets and other safer needle devices for the purpose of glucose monitoring and insulin administration.

By submitting this Diabetes Medication Administration Form, I am requesting that my child be provided with specific health services by the Department and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH).I understand that part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this form. I understand that the Department, DOHMH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this form. I further understand that the Department, DOHMH and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by the Department or DOHMH to provide the services requested, but, rather, my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department, DOHMH and their, employees, and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist.

Please Print Parent/Guardian's Name & Address Below:

_____ _____

Parent/Guardian's Signature

_____ _____

Date Signed

_____ _____

Daytime Telephone No. **Home Telephone No.**

(DO NOT WRITE BELOW – FOR DOE AND DOHMH ONLY)

Student's Name: _____ OSIS No: _____

Received by: _____ _____ Reviewed by: _____ _____
Name Date Name Date

Referred to School 504 Coordinator: ☐ Yes ☐ No Self-Monitors: ☐ Yes ☐ No

Services provided by: ☐ Nurse ☐ DOHMH Public Health Adv. ☐ School Based Clinic ☐ DOE School Staff

Signature and Title: _____ _____
(RN OR SMD) (Date school notified and form forwarded to DOE Liaison)