DIABETES MEDICATION ADMINISTRATION FORM – OFFICE OF SCHOOL HEALTH

Authorization for Administration of Medication in School to Students for School Year 2016-2017

Student Last Name	First Name	Middle	**Date of birth**_____/____/_____ M M D D Y Y Y Y	☐ Male ☐ Female	**OSIS #** ____ _____
School (include name, number, address and borough)			**DOE District** _____	**Grade**	**Class**

☐ **Type 1 Diabetes** ☐ **Type 2 Diabetes** ☐ **Other Diagnosis:** **Recent A1C:** Date____/____/_____ **Result**_____. **%**

EMERGENCY ORDERS

Severe Hypoglycemia
Administer **Glucagon** and **call 911**
☐ 1 mg SC/IM
☐ ___ mg SC/IM
Give PRN: unconsciousness, unresponsiveness, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration.

Risk for Diabetic Ketoacidosis (DKA)
☐ Test **ketones** if hyperglycemic, vomiting, or fever ≥100.5
- If small or trace give water; re-test ketones & bG in ___ hrs
- If initial or retest ketones are moderate or large, give water
  - ☐ Call parent and PMD
  - ☐ No Gym
  - ☐ If vomiting, unable to take PO, and MD not available, **CALL 911**
  - ☐ Give insulin correction dose if > __ hours since last insulin.

BLOOD GLUCOSE (bG) MONITORING

- ☐ Student may check bG without nurse supervision.
- ☐ Student to check bG with nurse supervision.
- ☐ Nurse / school personnel must check bG.

INSULIN ADMINISTRATION

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised student: student self-administers, under adult supervision
- ☐ Independent Student: Self-carry / Self-administer:*
  I attest student demonstrated the ability to self-administer the prescribed medication effectively for school/field trips/school/sponsored events: _____ (practitioner's initials)

***PARENT MUST INITIAL REVERSE SIDE**

MONITORING	☐ At LUNCH Time	☐ At SNACK Time**	☐ At GYM Time	☐ PRN
Hypoglycemia	**For bG< _ _ _ mg/dL** **Give** ___ oz juice, or ___ glucose tabs, or ___ grams carbs. **Re-check** in __ minutes; if bG <_ _ _ repeat carbs and re-check **until bG >**_ _ _. **THEN** Insulin is given **BEFORE** Lunch, **unless** otherwise indicated. ☐ Give insulin **AFTER** Lunch	**For bG< _ _ _ mg/dL** **Give** ___ oz juice, or ___ glucose tabs, or ___ grams carbs. **Re-check** in __ minutes; if bG <_ _ _ repeat carbs and re-check **until bG >**_ _ _. **THEN** Insulin is given **BEFORE** Snack, **unless** otherwise indicated. ☐ Give insulin **AFTER** Snack**	**For bG< _ _ _ mg/dL** **Give** ___ oz juice, or ___ glucose tabs, or ___ grams 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 to Gym	**For bG< _ _ _ mg/dL** **Give** ___ oz juice, or ___ glucose tabs, or ___ grams carbs. **Re-check** in minutes; if bG <_ _ _ repeat carbs and re-check **until bG >**_ _ _. ☐ Give Snack** **AFTER** treatment
	Use pre-treatment bG to calculate insulin dose, unless otherwise prescribed			
Between hypo & hyperglycemia	Insulin is given **BEFORE** Lunch, **unless** otherwise instructed. ☐ Give insulin AFTER Lunch	Insulin is given **BEFORE** Snack, **unless** otherwise instructed. ☐ Give insulin AFTER Snack**	☐ Give Snack** **BEFORE** Gym	
Hyperglycemia bG > _ _ _ mg/dL	**Test ketones if bG> _ _ _ mg/dL and manage as above for DKA:** applies to all times (otherwise use space in Other Orders)			
	Insulin is given **BEFORE** Lunch, **unless** otherwise instructed. ☐ Give insulin **AFTER** Lunch	Insulin is given **BEFORE** Snack, **unless** otherwise instructed. ☐ Give insulin **AFTER** Snack**	☐ For bG> _ _ _. No Gym ☐ For bG> _ _ _. AND at least _ hours since last insulin, give insulin correction	☐ For bG> _ _ _. No Gym ☐ For bG> _ _ _. AND at least _ hours since last insulin, give insulin correction
Carb Coverage Insulin Instructions	☐ Carb coverage **ONLY** ☐ Carb coverage **PLUS** Correction Dose when bG > Target bG AND at least __ hours since last insulin	☐ Carb coverage **ONLY** ☐ Carb coverage **PLUS** Correction Dose when bG > Target bG AND at least _ hours since last insulin	****SNACK** Student may carry and self-administer snacks: ☐ Yes ☐ No Time of day_____AM _____PM Type, Amount _____ ☐ **NO INSULIN TO BE GIVEN AT SNACK TIME**	

INSULIN ORDERS (CHECK ONE)	☐ **Correction Dose Method** (with or without Carb Coverage) using: ☐ Insulin Sensitivity Factor or ☐ Sliding Scale	☐ Sliding Scale	☐ Fixed Dose (enter time and dose in Other Orders box)	☐ No Insulin at School Glucose Monitoring ONLY

Name of Insulin: ☐ **Syringe** ☐ **Pen** ☐ **Insulin Pump (Brand):**

Target bG = _ _ _ mg/dL	Insulin Sensitivity Factor (ISF) **1 unit** decreases bG by_ _mg/dL	Insulin to Carbohydrate Ratio (I:C) For LUNCH: 1 unit: per _ _ grams carbs For SNACK: 1 unit: per _ _ grams carbs	**Basal Rate In School** _ . _ units/hour _ _ to _ _ AM / PM _ . _ units/hour _ _ to _ _ AM / PM	**Basal Rate for Gym** _ _ _ . _ percent for ___ hours ☐ Disconnect Pump for gym

Correction Dose by ISF: (bG – Target bG) / Insulin Sensitivity Factor = _ . _ units insulin

Carb Coverage: # grams carb in meal / # grams carb in I:C = _ . _ units insulin

☐ **Follow Pump recommendation** for bolus dose (If not using Pump recommendation, round dose DOWN to nearest **0.1** unit).
☐ For bG > _ _ _ mg/dL that has not decreased _ hours after correction, consider pump failure and notify parent.
☐ For suspected pump failure: DISCONNECT pump; give insulin by syringe or pen.

*Round **DOWN** insulin dose to the closest **0.5 unit** for syringe/pen or to the nearest **whole unit** if the syringe/pen doesn't have half-units: **unless** otherwise instructed by the PCP/endocrinologist.*

Sliding Scale
Do NOT overlap ranges (e.g., enter as 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given.

☐ **Pre-Lunch** ☐ **Pre-Snack** ☐ **Correction dose**

bG Range mg/dL		Insulin
0		

☐ **Other time**

bG Range mg/dL		Insulin Units
0		

Home Medications	**Dose**	**Frequency**	**Time**
Insulin:			
Oral:			

OTHER ORDERS (such as "Fixed Dose" orders, adjustments for rounding)

Health Care Practitioner (Please Print) LAST NAME	FIRST NAME	Signature	Date __ __ / __ __ / __ __ __ __
Address	Tel. (_ _ _)_ _ _- _ _ _ _	Fax. (_ _ _)_ _ _- _ _ _ _	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**
NYS License # **(Required)** _____	Medicaid# _ _ _ _ _ _ _ _ _ _	NPI # _ _ _ _ _ _ _ _ _ _	

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

Rev 5/16

Last Name	First Name	MI	**Date of birth**_____/_____/ _____	**School**
Student				

MONITORING BLOOD SUGAR, MEDICATION AND DIETARY NEEDS:

PARENT/GUARDIAN'S CONSENT 2016–2017

I hereby consent to:

(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 or school-sponsored activities, in accordance with the attached instructions of his/her health care practitioner.

I hereby consent to the storage and administration of medication, as well as the storage and use of necessary equipment to administer medication, in accordance with the instructions of my child's health care practitioner. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that if I provide any medication, it must be supplied in its original and UNOPENED medication box. I understand that I must furnish all necessary snacks, equipment and supplies and that I must immediately advise the school nurse, of any change in the prescription or instructions stated above.

I understand that this consent is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction program session; or such time that I deliver to the school nurse a new prescription or instructions issued by my child's health care practitioner regarding the administration of the above-prescribed monitoring and treatment (whichever is earlier).

I recognize that the New York City Department of Health and Mental Hygiene ("DOHMH"), DOE, and their agents have 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 DOHMH through the Office of School Health ("OSH"). I understand that part of these services may entail a clinical assessment and/or physical examination by an OSH health care practitioner. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this form. I understand that OSH, 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. I recognize that this form is not an agreement by OSH or DOE to provide the services requested, but, rather, my request and consent 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 understand that OSH and DOE and their employees, and agents may 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 practitioner and/or pharmacist that has provided medical or health services to my child.

****SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications):**

_____I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further consent to my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, and for any and all consequences of my child's use of such medication in school. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

_____ I consent to the school nurse to storing and/or administering to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

Parent/Guardian's Signature	**Print Parent/Guardian's Name**
Date Signed ____/_____/ _____	**Parent/Guardian's Address**
Telephone Numbers: **Daytime** (_____)_____-_____ **Home** (_____)_____-_____ **Cell Phone*** (_____)_____- _____	
Parent/Guardian e-mail address*	
Alternate Emergency Contact's Name	**Contact Telephone Number** (_____)_____- _____

DO NOT WRITE BELOW – FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

Received by: Name Date____/____/ _____	**Reviewed by**: Name Date____/____/ _____
bG monitoring without supervision: ☐ Yes ☐ No	**Insulin administration without supervision:** ☐ Yes ☐ No
Services provided by: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center	
Signature and Title (RN OR MD/DO/NP):	
Revisions per OSH after consultation with prescribing health care practitioner.	