MAMARONECK UNION FREE SCHOOL DISTRICT

DIABETES MEDICATION ADMINISTRATION FORM

Provider Medication Order Form—Office of School Health—

Student Last Name	First Name	Middle	Date of birth_____/____/_____ M M D D Y Y Y Y	☐ Male ☐ Female	
School				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 bG > ___ mg/dl, or if vomiting, or fever ≥ 100.5F

- 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 SKILL LEVEL

☐ Student may check bG without supervision.

☐ Student to check bG with nurse/school staff supervision.

☐ Nurse / school personnel must check bG.

INSULIN ADMINISTRATION SKILL LEVEL

☐ Nurse-Dependent Student: nurse must administer medication

☐ Supervised student: student self-administers, under supervision

☐ Independent Student: Self-carry / Self-administer:*

_____ practitioner's initials

I attest student demonstrated the ability to self-administer the prescribed medication effectively for school, field trips, & school/sponsored events ***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	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 ☐ Correction Dose **ONLY**	☐ Carb coverage **ONLY** ☐ Carb coverage **PLUS** Correction Dose when bG > Target bG AND at least _ hours since last insulin ☐ Correction Dose **ONLY**	****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** ☐ **Hold snack if bG > _____ mg/dl**	

☐ **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: _____ **Delivery Method:** ☐ **Syringe** ☐ **Pen** ☐ **Insulin Pump (Brand):**

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

*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.*

☐ **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.

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. (____)____-_____

NYS License # **(Required)** _____ NPI # _____

CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.

Print Parent/Guardian's Name **Parent/Guardian's Signature**

Date Signed _____/_____/_____