學校健康辦公室

糖尿病藥物施用表

保健提供者囑咐的藥物用法表 | **2025-26**學年

請將所有的糖尿病藥物施用表(DMAF) 傳真到347-396-8932/8945。

藥物施用指示將在表格遞交並獲批准後予以執行。如果您希望藥物施用指示在2015年9月開始執行，請在此打勾 ☐

學生姓氏：_____ 名字：_____ 出生日期：_____ 性別 ☐ 男 ☐ 女 OSIS#：_____

學校ATSDBN/名稱：_____ 地址：_____ 行政區：_____ 學區：_____ 年級/班級：_____

HEALTH CARE PRACTITIONER COMPLETES BELOW ***[Please see 'Provider Guidelines for DMAF Completion']***

Section A: Diagnosis

A1. Diagnosis
Diabetes Mellitus ☐ Type 1 ☐ Type 2 ☐ Other:_____ Dx Date ____/____/_____

A2. Recent A1c
Date ____/____/_____ Result: _____ . _____ (%)

SECTION B: Emergency Orders

B1. Severe Hypoglycemia
ADMINISTER GLUCAGON AND CALL 911

Glucagon	GVOKE	Baqsimi	Zegalogue
☐ 1 mg SC/IM	☐ 1 mg SC/IM	☐ 3 mg Intranasal	☐ 0.6 mg SC
☐ 0.5 mg SC/IM	☐ 0.5 mg SC/IM		May repeat in 15 min PRN

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.

B1. Risk for Diabetic Ketoacidosis (DKA)
CALL 911 IF POSITIVE KETONES AND VOMITING, UNABLE TO TAKE PO, ALTERNED MENTAL STATUS, OR BREATHING CHANGES

Test ketones if any of the following:
- vomiting
- fever ≥ 100.5 F
- bG > _____ mg/dl for the
  ☐ FIRST ***OR*** ☐ SECOND time that day, ≥ 2 hrs apart

If ketones small or trace, give water, re-test ketones & bG in 2 or ____ hrs

If ketones moderate or large, give water, **call**
☐ Give insulin correction dose if ≥ 2 hrs or ____ hrs since last rapid acting insulin
☐ NO GYM

SECTION C: Glucose Monitoring

C1. Glucose Monitoring Times
☐ PRN
☐ Breakfast
☐ Lunch
☐ Snack
☐ Gym
☐ Dismissal
☐ No bG monitoring

C2. Continuous Glucose Monitor Use *(Must complete Section G)*
☐ Use CGM readings for glucose monitoring
☐ Use CGM readings for insulin dosing
For CGMs to be used for glucose monitoring and/or insulin dosing, devices must be FDA approved for use and age and used within the limits of the manufacturer's protocol.

SECTION D: Skill Level *(If incomplete or attestation not initiated, default is nurse dependent)*

D.1 Glucose Monitoring	D2. Insulin Calculation & Administration
☐	☐
☐	☐
☐	☐

_____
Provider Initials

Skill Level: Skills include finger sticks, glucometer and/or CGM use, insulin dose calculation, and insulin administration only nurses or supervised/independent students may calculate/administer insulin
Nurse dependent: Nurse or trained staff must perform
Supervised: Student to perform with adult supervision
Independent: Student carries supplies & self-administers
FOR INDEPENDENT MEDICATION ADMINISTRATION: I attest

SECTION E: Glucose Monitoring Parameters

E1. Hypoglycemia (*Provide additional hypoglycemia instructions in Section I: Other Orders*)

E1a. Oral Hypoglycemia Treatment
☐ For bG < 70 mg/dl or <_____ mg/dl, give 15 g or ____ g rapid carbs at PRN and ☐Breakfast ☐Lunch ☐Snack ☐Gym ☐Dismissal
Recheck bG in 15 or ____ min until bG > 70 mg/dl or _____ mg/dl

☐ For bG < _____ mg/dl, give ____ g rapid carbs at ☐PRN ☐Breakfast ☐Lunch ☐Snack ☐Gym ☐Dismissal
Recheck bG in 15 min or ____ min until bG > _____ mg/dl

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

E1b. Pre-Gym Hypoglycemia Orders
☐ For bG < _____ mg/dl, no gym
☐ For bG < _____ mg/dl, treat hypoglycemia then give uncovered snack*
☐ For bG < _____ mg/dl, give uncovered snack*

E1c. Pre-Dismissal Hypoglycemia Orders
☐ For bG < _____ mg/dl, treat hypoglycemia PRN, and give ____ g carb snack before dismissed
☐ For bG < _____ mg/dl, treat hypoglycemia PRN, call parent to pick up

*Snacks provided by staff will be between 15-25 g carbs unless otherwise specified in Section I: Other Orders

E2. Hyperglycemia
☐ For bG > _____ mg/dl pre-gym, ☐ no gym and ☐ check ketones (no gym applies regardless of ketones, for ketone parameters, see Section B2)
☐ For bG > _____ mg/dl PRN, give insulin correction if ≥ 2 hrs or ____ hrs since last rapid acting insulin

bG "HI" reading = 500 mg/dl or _____ mg/dl

SECTION F: Insulin Orders

F1. Insulin Name
_____ ☐ No insulin in school
** May substitute Novolog with Admelog/Humalog*

F2. Insulin Delivery Method
☐ Syringe/Pen ☐ Smart Pen - use pen suggestions
☐ Pump (Brand) **If left blank, will use syringe/pen*
_____
**For iLet, must complete iLet Pump Orders Form*

F3. Insulin Pump Orders
☐ Student on FDA approved hybrid closed loop pump – basal rate variable per pump
☐ Follow pump recommendations for bolus doses
☐ Suspend/disconnect pump for hypoglycemia not responding to treatment for _____ min
☐ Suspend/disconnect pump for gym
☐ Activity Mode: Start 60 min or ____ min prior to exercise until 120 min or ____ min after exercise

F4. Concern for Pump Failure/Pump Dislodgement
☐ For bG > _____ mg/dl that has not decreased in ____ hrs after correction, consider pump failure and notify parents
☐ For suspected pump failure/dislodgement, SUSPEND pump and give rapid acting insulin by syringe/pen
☐ For pump failure/dislodgement, only give correction dose if > ____ hrs since last rapid acting insulin
☐ In the setting of pump failure/dislodgement, do not use the pump to calculate insulin correction doses

F5. Insulin Calculation Methods
F5a. Correction Dose Using: ☐ ISF ☐ Sliding Scale
F5b. Carb Coverage Using: ☐ I:C ☐ Sliding Scale ☐ Fixed Dose
F5c. Insulin Dosing for Meals:

Insulin Dose	Meal: Breakfast	Lunch	Snack
Carb Coverage Dose	☐	☐	☐
Correction Dose	☐	☐	☐

When carb coverage and correction doses are given at the same time, correction dose will be added when bG > target ***and*** ≥ 2 hrs or ____ hrs since last rapid acting insulin unless otherwise specified

F5d. Exceptions to Pre-Food Insulin Administration
☐ If bG> _____ mg/dl, give correction dose pre-meal and carb coverage after meal
☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

Carb Coverage using I:C
g carb in meal / I:C = X units insulin

Correction using ISF
bG – target bG / ISF = Y units insulin

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.

F6. Insulin Dose Calculation Ratios
Times will be 7am – 4pm if not specified

F6a. Target bG
_____ mg/dl from time _____ to _____

_____ mg/dl from time _____ to _____

F6b. Insulin Sensitivity Factor (ISF)
1 unit decreases bG by:
_____ mg/dl from time _____ to _____
_____ mg/dl from time _____ to _____

F6c. Insulin:Carb Ratio (I:C)
Time _____ to _____ ***OR*** Breakfast
1 unit per ____ g carbs
Time _____ to _____ ***OR*** Lunch
1 unit per ____ g carbs
Time _____ to _____ ***OR*** Snack
1 unit per ____ g carbs

☐ If gym/recess is immediately following meal, subtract ____ g carbs from meal carb calculation

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學生姓氏：_____ **名字：**_____ **出生日期：**_____ **OSIS #** _____

SECTION F: Insulin Orders (Continued)

F7. Sliding Scales (*Provide additional sliding scales in Section I: Other Orders*)
Do **NOT** overlap ranges (e.g., enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. You must provide a range from 0 to "high" bG, which is 500 mg/dl unless otherwise specified in Section E2: Hyperglycemia. Use pre-treatment bG to calculate insulin dose unless specified in Section I: Other Orders.

F8. Fixed Dosing for Carb Coverage
Correct bG using method in Section F5a: Correction Dose and for carb coverage ADD:
- ☐ ____ units for breakfast
- ☐ ____ units for lunch
- ☐ ____ units for snack

F7a. Correction Dose

bG (mg/dl)		Units
Zero	-	0
	-	
	-	
	-	
	-	
	-	
	-	

F7b. Carb Coverage *PLUS* Correction Dose

bG (mg/dl)		Units	Use For:
Zero	-	0	☐ Breakfast
	-		☐ Lunch
	-		☐ Snack
	-		☐ See attached
	-		
	-		
	-		

F9. Alternate Rounding Instructions
- ☐ Round insulin dosing to nearest whole unit: 0.50-1.49u rounds to 1u
- ☐ For half unit pen/syringe, round insulin dosing to nearest half unit: 0.25-0.74u rounds to 0.5u

F10. Long-Acting Insulin
- ☐ Give long-acting insulin at school
  - Name: _____
  - Dose: ____ units
  - Time: _____ ***OR*** pre-lunch
  - Long-acting insulin may be given at the same time as rapid-acting insulin at a different

SECTION G: Continuous Glucose Monitoring (CGM) Orders *[Please see 'Provider Guidelines for DMAF Completion']*

G1. Name and Model of CGM: _____

For CGMs to be used for glucose monitoring and/or insulin dosing, devices must be FDA approved for use and age and used within the limits of the manufacturer's protocol and in accordance with manufacturer's instructions. For CGM used for insulin dosing, finger stick bG will be done when symptoms don't match the CGM readings or 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). For sG < 70mg/dl, check bG and follow hypoglycemia orders on DMAF, unless otherwise ordered below.

G2. CGM Instructions: Use CGM grid below ***OR*** ☐ see attached CGM instructions.

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 sG still < 70 mg/dl, check bG.
sG 60-69 mg/dl	↓, ↓↓, ↘ or →	Treat hypoglycemia per bG hypoglycemia plan. Recheck in 15-20 min. If sG still < 70 mg/dl, check bG.
sG 60-69 mg/dl	↑, ↑↑, or ↗	If symptomatic, treat hypoglycemia per bG hypoglycemia plan. If asymptomatic, recheck in 15-20 min. If sG 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	↓, ↓↓	Give 15 g uncovered carbs. If gym or recess is immediately after lunch, subtract 15 g of carbs from lunch carb calculation.
sG ≥ 250 mg/dl	Any arrows	Follow bG DMAF orders for treatment and insulin dosing.
☐ For student using CGM, wait 2 hours after a meal before testing for ketones with hyperglycemia		

SECTION H: Parental Input into Dosing

Parent(s)/Guardian(s) (**MUST 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 provider and in keeping with nursing judgement.

SELECT ONE

- ☐ Nurse may adjust calculated dose up or down up to ____ units based on parental input and nursing judgment
- ☐ Nurse may adjust calculated dose up by ____ % or down by ____ % of the prescribed dose based on parental input and nursing judgement.

MUST COMPLETE: Health care provider 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 provider to see if the school orders need to be revised.

SECTION I: Other Orders

_____

_____

_____

_____

SECTION J: Home Medications

Medication	Dose	Route	Frequency	Time

SECTION K: Additional Information

Is the child using altered or non-FDA approved equipment? ☐ **Yes** ☐ **No** [*Please note that New York State Education laws prohibit nurses from managing non-FDA approved devices. For nurse to administer insulin at school, you must provide pump failure and/or back up orders on DMAF page 1.*]

By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s).

Health Care Provider
(PLEASE PRINT)

Last Name:_____ First Name (Print): _____ Signature: _____ Date: _____

Credentials: ☐ MD ☐ DO ☐ NP ☐ PA

Address: _____ City/State: _____ ZIP: _____ Email address: _____

NYS License # or NPI # (Required): _____ Tel: _____ FAX: _____

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

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學生姓氏：_____ **名字：**_____ **出生日期：**_____ **性別 ☐ 男 ☐ 女 OSIS#：**_____

學校ATSDBN/名稱：_____ 地址：_____ 行政區：_____ 學區：_____ 年級/班級：_____

各位家長和監護人：通讀、填寫並簽名。我在下面簽名，表示我同意如下：

1. 我同意，根據我子女保健服務提供者的說明和所確定的技能水平，護士/學校健康中心（SBHC）服務提供者可以為我的子女施用我子女的處方藥物，且護士/經訓練的教職工/SBHC服務提供者可以檢查我子女的血糖，並處理我子女的低血糖問題。這些措施可以在學校場地或在學校組織的外出活動途中進行。
2. 我也同意，我子女的醫藥所需的任何器材都在學校裏儲存和使用。
3. 我理解：
   - 我必須將我子女的醫藥品、點心、器材及有關用品交給學校護士/SBHC服務提供者，並必須按需要補充這些醫藥品、點心、器材及有關用品。學校健康辦公室（OSH）建議使用安全採血針和其他安全針具及相應用品檢查我子女的血糖水平和補給胰島素。
   - 我同意按照子女504會議所述，讓子女在學校和學校外出活動時攜帶並儲存其使用的藥品/有關用品。
   - 我給予學校的所有處方和非處方藥物都必須是新的、未曾開封過並裝在其原封瓶子或盒子裏。我將給學校提供我子女在上學日所需的當前、未過期的醫藥用品。
     - 處方藥物必須在其盒子或瓶子上有原裝藥房標籤。標籤必須包括：**1)** 我子女的姓名；**2)** 藥房名稱和電話號碼；**3)** 我子女的保健服務提供者姓名；**4)** 日期；**5)** 重配次數；**6)** 藥物名稱；**7)** 劑量；**8)** 何時用藥；**9)** 如何用藥；**10)** 任何其他說明。
   - 如果我子女的藥物或者保健服務提供者的說明有任何變化，我必須**立即**告知學校護士/SBHC提供者。
   - 參與為我子女提供上述健康服務的學校健康辦公室（OSH）及其代理人員依賴於本表格資訊的精確度。
   - 我在這一「藥物施用表」（MAF）上簽名，表示授權學校健康辦公室（OSH）為我子女提供糖尿病相關的健康服務。這些服務可以包括（但不限於）由一名OSH辦公室保健服務提供者或護士所執行的臨床評估或體檢。
   - 這份MAF表所囑咐的藥物用法在以下時間失效：我子女的學年結束時（這可能包括暑期班），或者在我交給學校護士/SBHC服務提供者一份新的MAF時（以時間較早者為準）。當這份囑咐的藥物用法表失效時,我將交給子女的學校護士/SBHC服務提供者一份新的由我子女的保健服務提供者出具的MAF。
   - 學校健康辦公室（OSH）和教育局（DOE）負責確保我的子女能夠安全地測試自己的血糖。
   - 這份表格代表我同意並要求提供本表格內說明的糖尿病服務，並可以直接發送給學校健康辦公室（OSH）。這並非OSH提供所要求的服務的協議。如果OSH決定提供這些服務，我子女可能還需要一份「學生特別照顧計劃」（Student Accommodation Plan）。這份計劃將由學校填寫。
   - 爲著給我子女提供護理或治療的目的，OSH可以獲取該辦公室認爲所需要的有關我子女的健康問題、藥物和治療相關的任何其他資訊。OSH可以向任何為我子女提供健康服務的保健服務提供者、護士或藥劑師索取該資訊。

請注意：最好是您在學校外出活動的日子和在校外進行學校活動時給子女帶上藥物和器材。

用於詢問有關糖尿病藥物施用表（DMAF）的問題的OSH家長熱線：718-786-4933

自己用藥和/或進行醫療程序（僅適用於能自己獨立用藥的學生）：

- 我證明/確認，我子女已得到完全的訓練並能夠自行用藥和/或進行醫療程序。我同意，我的子女在學校裏以及在學校外出活動時自己攜帶、儲存並施用本表格上所開具的藥物。我負責根據上述說明把瓶子或盒子裏的藥物交給我子女。我也負責監督我子女在學校裏的藥物使用情況及其對這一藥物使用所導致的任何後果。學校護士或SBHC服務提供者將確認我子女擁有攜帶和自行用藥的能力。我也同意交給學校「備用」藥物（裝在清楚地標示的盒子或瓶子裏）。
- 如果我的子女暫時無法攜帶藥品和用藥，我同意學校護士或受過訓練的學校員工按照保健服務提供者所開具的處方給我的子女施用胰高血糖素。

家長/監護人在下方簽名

工整填寫家長/監護人姓名：_____ **家長/監護人為A和B部分簽名：**_____ 日期：_____

家長/監護人地址: _____ 家長/監護人的電子郵箱：_____

緊急聯絡號碼 最佳聯絡電話號碼：_____ 住家電話號碼：_____ 手機號碼：_____

其他緊急聯絡人姓名：_____ 與學生的關係：_____ 聯絡電話號碼：_____

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