學生照片附此

糖尿病藥物施用表（Diabetes Medication Administration Form）

提供者醫療手續執行表 - 學校健康辦公室 - **2019-2020學年**

截止日期：5月31日。5月31日之後遞交的表格可能延遲受理新學年服務的申請。。請將所有的糖尿病藥物使用表(DMAF) 傳真到347-396-8932/8945。

Student Last Name	First Name	MI	**Date of birth**	☐ Male ☐ Female	**OSIS #**
School (include ATSDBN/name, address and borough)			**DOE District**	**Grade**	**Class**

HEALTH CARE PRACTITIONER COMPLETES BELOW (保健專業人員填寫以下內容)

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ non-Type 1/Type 2 Diabetes ☐ Other Diagnosis: Recent A1C: Date / / Result . %

Orders written will be for Sept. '19 through Aug '20 school year unless checked here: ☐ Current School Year '18-'19

Emergency Orders

Severe Hypoglycemia
Administer **Glucagon** and **call 911**
☐ 1 mg SC/IM ☐ ___mg SC/IM

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration.

For Independent or supervised student: a trained adult will carry glucagon on school trips.

Risk for Ketones or Diabetic Ketoacidosis (DKA)
☐ Test **ketones** if bG >___mg/dl, or if vomiting, or fever > 100.5F **OR**
☐ Test ketones if bG >__mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5F
- If small or trace give water; re-test ketones & bG in 2 hrs or ___ hrs
- If initial or retest ketones are moderate or large, give water:
  Call parent and Endocrinologist; ☐ **NO GYM**
  If ketones and vomiting, unable to take PO and MD not available, **CALL 911**

☐ Give insulin correction dose if > 2 hrs or __ hours since last insulin.

Blood Glucose (bG) Monitoring Skill Level
☐ Nurse / adult must check bG.
☐ Student to check bG with adult supervision.
☐ Student may check bG without supervision.

Insulin Administration Skill Level
☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised student: student self-administers, under adult supervision
☐ Independent Student: Self-carry / Self-administer *(Initial below)*
NOTE: Trip nurse not required for supervised or independent students.

I attest student demonstrated the ability to self-administer the prescribed medication effectively for school, field trips, & school/sponsored events — PROVIDER INITIALS

bG Monitoring: Specify times to test in school (must match times for treatment and/or insulin) ☐ Breakfast ☐Lunch ☐ Snack ☐ Gym ☐ PRN
☐ Use CGM readings **(must complete DMAF Addendum form)**

Hypoglycemia: *Check all boxes needed. Must include at least one treatment plan.*
☐ For bG < _____mg/dl give _____ gm rapid carbs at: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN
Repeat bG testing in 15 or ____ min. If bG still < _____mg/dl repeat carbs and retesting until bG > _____ mg/dl.
☐ For bG < _____mg/dl give _____ gm rapid carbs at: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN
Repeat bG testing in 15 or ____ min. If bG still < _____mg/dl repeat carbs and retesting until bG > _____ mg/dl.
☐ For bG < _____mg/dl pre-gym, **no gym** ☐ For bG < _____mg/dl ☐ Pre-gym; ☐ PRN; treat hypoglycemia then give snack.
Insulin is given before food unless otherwise noted here: ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

Mid-range Glycemia:
Insulin is given before food unless otherwise noted here: ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give snack before gym

Hyperglycemia:
Insulin is given before food unless otherwise noted here: ☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack
☐ No Gym For bG > ___mg/DL ☐ Pre-gym and/or ☐ PRN
☐ For bG > ___ mg/dL PRN, Give insulin correction dose if > __ hrs. since last insulin
☐ For bG meter reading "**High**" use bG value of ___ mg/dl. *If not specified, Nurse will use bG value of 500 mg/dl.*

Insulin orders:
Name of Insulin:
_____
☐ No Insulin in School
☐ No Insulin at Snack time
Delivery Method:
☐ Syringe/Pen
☐ Pump *(Brand)*: _____
☐ Smart Pen – use pen suggestions
☐ Parent may have input into insulin dosing. **See DMAF Addendum.**

Insulin Calculation Method:
☐ Carb coverage **ONLY** at: ☐ Breakfast ☐ Lunch ☐ Snack
☐ Correction dose **ONLY** at: ☐ Breakfast ☐ Lunch ☐ Snack
☐ Carb coverage **plus** correction dose when bG > Target **AND** at least 2 hrs or ___ hrs. since last insulin at ☐ Breakfast ☐ Lunch ☐ Snack
Correction dose calculated using: ☐ ISF **or** ☐ Sliding Scale
☐ Fixed Dose (**see Other Orders**)
☐ Sliding Scale (**See Addendum**)
☐ If Gym/recess is immediately following lunch, subtract ___ gm carbs from lunch carb calculation.
Use pre-treatment bG to calculate insulin dose unless otherwise ordered.

Insulin Calculation Directions: *(give number, not range)*

Target bG = ___ mg/dl
Insulin Sensitivity Factor (ISF):
1 unit decreases bG by ___ mg/dl (time:_____ to _____)
1 unit decreases bG by ___ mg/dl: (time:_____ to _____)
If only one ISF, time will be 8am to 4pm if not specified.

Insulin to Carb Ratio (I:C):
Lunch:
1 unit per ___ gms carbs **OR** time:_____to _____
Snack:
1 unit per ___ gms carbs **OR** time:_____to _____
Breakfast:
1 unit per ___ gms carbs **OR** time:_____to _____

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

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.

For Pumps - Basal Rate in school:
__:___ AM/PM to __:__ AM/PM __:___ units/hr
__:___ AM/PM to __:__ AM/PM __:___ units/hr
__:___ AM/PM to __:__ AM/PM __:___ units/hr
☐ Student on FDA approved hybrid closed loop pump-basal rate variable per pump.
☐ Suspend/disconnect pump for gym
☐ Suspend pump for hypoglycemia not responding to treatment for ____ min.

Additional Pump Instructions:
☐ Follow pump recommendations for bolus dose *(if not using pump recommendations, will round down to nearest 0.1 unit)*
☐ For bG > ___ mg/dl that has not decreased in __ hours after correction, consider pump failure and notify parents.
☐ For suspected pump failure: SUSPEND pump, give insulin by syringe or pen, and notify parents.
☐ For pump failure, only give correction dose if > __hrs since last insulin

Other Orders:

Home Medications (in case of emergency e.g. school lock down)

Medication	Dose	Frequency	Time	Route
Insulin:				
Other:				

Health Care Practitioner Name LAST (**Please print and circle one:** MD, DO, NP, PA)	FIRST	Signature	Date
Address		Tel. (__ __ __) __ __ __ - __ __ __ __	Fax. (__ __ __) __ __ __ - __ __ __ __
NYS License # **(Required)**	NPI #	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**	

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家長/監護人填寫以下內容

我在下面簽名，表示我同意如下：

1. 我同意，根據我子女保健專業人員的說明和所確定的技能水平，護士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參觀途中進行。
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、零食、器材及有關用品交給學校護士，並必須按需要補充這些醫藥品、零食、器材及有關用品。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。
   - **我所給予學校的所有處方和非處方藥物都必須是新的、未曾打開過並裝在其原封瓶子或盒子裏。將給學校提供供我子女在上學日內使用的當前、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) 我子女的保健專業人員姓名， 4) 日期， 5) 重配次數， 6) 藥物名稱， 7) 劑量， 8) 何時用藥， 9) 如何用藥以及 10) 任何其他說明。
   - 如果我子女的藥物發生任何變化或者保健專業人員的說明有任何變化，我必須**立即**告知學校護士。
   - 涉及到給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）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 辦公室保健專業人員或護士所執行的一次臨床評估或一次體檢。
   - 這份 MAF 表的醫療執行手續的過期時間是我子女的學年結束（這可能包括暑期班）或者當我交給學校護士一份新的 MAF（取兩者中較早的那個時間）。
   - OSH 和教育局（DOE）負責確保我的子女能夠安全地測試其血糖。
   - 這份表格表明我對本表所說明的糖尿病服務的同意和要求。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有關我子女的醫療狀況、藥物和治療而需要的任何其他資訊。OSH 可以從任何為我子女提供健康服務的保健專業人員、護士或藥劑師那裏獲取該資訊。

自己用藥（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。我同意，我子女在學校裏自己攜帶、儲存本表所開具的藥物並將自己用藥。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產生的任何結果。學校護士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）。
- 我同意，如果我子女臨時不能攜帶或自行用藥，學校護士或經過訓練的學校員工可以給我子女施用藥物。

說明：最好是您在學校外出參觀的日子和在校外進行學校活動時給子女帶上藥物和器材。

學生 姓 名 中間名		出生日期__ __ / __ __ / __ __ __ __
學校 ATSDBN/名稱	行政區	學區
清楚填寫家長/監護人的姓名 **在此簽名**	**家長/監護人簽名**	簽名日期 __ __ / __ __/ __ __ __ __
家長/監護人電子郵箱	**家長/監護人地址**	

電話號碼 日間 (__ __ __) __ __ __ - __ __ __ __ **住宅** (__ __ __) __ __ __ - __ __ __ __ **手機*** (__ __ __) __ __ __ - __ __ __ __

其他緊急聯絡人姓名	**與學生的關係**	**聯絡電話**(__ __ __) __ __ __ - __ __ __ __

僅由學校健康辦公室填寫

OSIS Number: ☐ **504** ☐ **IEP** ☐ **Other**

Received by: Name Date___/___/_____ | **Reviewed by**: Name Date_____/___/_____

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor *(For supervised students only)* ☐ School Based Health Center

Signature and Title (RN OR MD/DO/NP):

Revisions per OSH after consultation with prescribing health care practitioner ☐ Modified ☐ Not Modified

**請不要使用電子郵件發送保密資訊

只供印刷用