# NYC OFFICE OF SCHOOL HEALTH – DIABETES MEDICATION ADMINISTRATION FORM
# SCHOOL YEAR 2010-2011

| 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 ☐ Type 2 Diabetes
☐ 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**<br>Give ______ oz juice, or ____ glucose tabs, or ____ gm carbs<br>Re-check in ______ minutes; if bG < ______ , repeat carbs and re-check until bG > ______ .<br>THEN<br>☐ **Give insulin, BEFORE Lunch**<br>☐ **Give insulin AFTER Lunch** | **For bG< _____ mg/dL**<br>Give ______ oz juice, or ____ glucose tabs, or ____ gm carbs<br>Re-check in ______ minutes; if bG < ______ , repeat carbs and re-check until bG > ______ .<br>THEN<br>☐ **Give insulin BEFORE Snack**<br>☐ **Give insulin AFTER Snack** | **For bG< _____ mg/dL**<br>Give ______ oz juice, or ____ glucose tabs, or ____ gm carbs<br>Re-check in ______ minutes; if bG < ______ , repeat carbs and re-check until bG > ______ .<br>☐ If initial bG < ____ , **No Gym**<br>☐ Give Snack **AFTER** treatment **THEN** send student to Gym | **For bG< _____ mg/dL**<br>Give ______ oz juice, or ____ glucose tabs, or ____ gm carbs<br>Re-check in ______ minutes; if bG < ______ , repeat carbs and re-check until bG > ______ .<br>☐ Give Snack after treating Hypoglycemia |
| Between Hypo- and Hyperglycemia | ☐ **Give insulin BEFORE Lunch**<br>☐ **Give insulin AFTER Lunch** | ☐ **Give insulin BEFORE Snack**<br>☐ **Give insulin AFTER Snack** | ☐ Give Snack **BEFORE** Gym<br>☐ Send to Gym | |
| Hyperglycemia* bG > ________ | ☐ **Test ketones if bG > ______ mg/dL**<br>Treat as per Risk for DKA above<br>☐ **Give insulin BEFORE Lunch**<br>☐ **Give insulin AFTER Lunch** | ☐ **Test ketones if bG > ______ mg/dL**<br>Treat as per Risk for DKA above<br>☐ **Give insulin BEFORE Snack**<br>☐ **Give insulin AFTER Snack** | ☐ **Test ketones if bG > ______ mg/dL**<br>Treat as per Risk for DKA above<br>For bG> _____ mg/dL **No Gym**<br>For bG> _____ mg/dL AND at least ____ hours since last insulin, **give insulin** | ☐ **Test ketones if bG > ______ mg/dL**<br>Treat as per Risk for DKA above<br>For bG> _____ mg/dL **No Gym**<br>For bG> _____ mg/dL AND at least ____ hours since last insulin, **give insulin** |
| Carb Coverage Insulin Instructions | ☐ Carb coverage ONLY<br>☐ Carb coverage PLUS Correction Dose when bG > Target bG | ☐ Carb coverage ONLY<br>☐ 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 |

***Round DOWN the insulin dose to the closest 0.5 units for syringe/pen***

**Carb Coverage** = # gms carb in meal / # gms carb in I:C = ______ units insulin    **Correction Dose** = bG – Target bG / 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:** 60 gms carb / 20 = 3 units **PLUS Correction Dose:** 250-150 / 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)* | | Tel. No. |
|---|---|---|
| Health Care Practitioner Signature | Date __ __/__ __/__ __ | Fax No. |
| Address | | NYS Lic. No. **(Required)** |

**For DOHMH USE: Revisions per consult with Prescriber:**
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SH-101 (Rev. 3/10)