NYC Health | Department of Health and Mental Hygiene | Department of Education

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | **First Name** | **Middle Name** | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | **State** | **Zip Code** | **School/Center/Camp Name** | **District Number** __ __ __

Phone Numbers Home _____ Cell _____ Work _____

Health insurance (including Medicaid)? ☐ Yes ☐ No

☐ **Parent/Guardian** ☐ **Foster Parent** **Last Name** **First Name** **Email**

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***

☐ None ☐ Yes *(list below)*

_____
_____
_____
_____

PHYSICAL EXAM **Date of Exam:** ___ / ___ / ___

Height _____ **cm** (___ ___ %ile)

Weight _____ **kg** (___ ___ %ile)

BMI _____ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No

Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment ***(at each well child exam, age 6 mo-6 yrs)***	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	*Results*
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision

	Date Done	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right _____ / _____ Left _____ / _____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/17/2023		
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		

Tdap	___/___/___	___/___/___	___/___/___						
MMR	___/___/___	___/___/___	___/___/___						
Varicella	___/___/___	___/___/___	___/___/___						
Mening ACWY	___/___/___	___/___/___	___/___/___						
Hep A	___/___/___	___/___/___	___/___/___						
Rotavirus	___/___/___	___/___/___	___/___/___						
Mening B	___/___/___	___/___/___	___/___/___						
Other _____	___/___/___	___/___/___							

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

_____ _____
_____ _____
_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __ __ / __ __ / __ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY **PRACTITIONER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

FORM ID#

AUTHORIZATION TO ADMINISTER MEDICATIONS

Written Physician and Parent Permission Form

Student Name: Date of Birth: Drug Allergies:

The following Over-The-Counter (OTC) medications are available at Dwight School's Health Office. Dwight School personnel can administer or assist my child in administering these OTC medications according to label instructions and weight during school hours and/or during Dwight School off-campus events, including overnight trips, **ONLY if Parent/Guardian AND Physician signature is documented below.**

Medication	Route of Administration	Schedule and Indications	Administer as Needed? (circle one)
Acetaminophen (Tylenol)	By mouth (liquid/chewable/tabs)	Q4h as needed for pain or fever > ____-F	Yes No
Ibuprofen (Motrin/Advil)	By mouth (liquid/chewable/tabs)	Q6h as needed for pain or fever > ____-F	Yes No
Diphenhydramine (Benadryl)	By mouth (liquid/tabs)	Q6h as needed for allergic reaction/hives/insect bites	Yes No
Loratadine (Claritin)	By mouth (liquid/tabs)	Once Daily for allergy symptoms	Yes No
Cepacol/Halls/Sore Throat Pops	By mouth	Q2h as needed for sore throat/cough	Yes No
Antacids (Tums)	By mouth (chewable)	Q4h as needed for upset stomach	Yes No
Neosporin/Bacitracin	Topically	Q4h as needed for cuts/scrapes	Yes No
Benadryl/Hydrocortisone	Topically	Q4h as needed for itch	Yes No
Calamine/Calaclear/Aquaphor/ Vaseline	Topically	Q4h as needed for itch/irritation	Yes No
Visine A.C. (Allergy Eye Drops)	Topically	Q4h as needed for allergy itch/irritation	Yes No
Saline Solution	Topically (eyes/nose)	Q4h as needed for dry/stuffy nose or cleaning/refreshing contact lenses	Yes No
Arnica/Menthol/Biofreeze	Topically	Q4h as needed for minor muscle or joint pain	Yes No
Sunscreen (broad-spectrum)	Topically	30 minutes prior to sun exposure and as needed for outdoor activities	Yes No

Please document below if this student requires **routine** OTC and/or Prescription medication administration during the school hours and/or off campus events other than those medications listed above. **That medication must be supplied by the parent and stored in the Health Office in the original packaging.** Dwight School personnel may **assist** this student with administration of that medication according to the physician's instructions listed below.

Diagnosis	Medication	Route	Frequency/Time	Comments

Physician/Healthcare Provider (New York, New Jersey, or Connecticut licensed)

Physician/Healthcare Provider's Name (print): _ License #: Phone #:

Signature: Date: **Parent/Guardian:**

Parent/Guardian Name (print):

Signature: Date:

This document will remain in effect until either the last day of my child's enrollment at Dwight, when the medication order/therapy changes, or when I cancel this authorization in writing.

Asthma Action Plan

Date Completed

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [◯ Mild ◯ Moderate ◯ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other _____

GREEN ZONE: GO!

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

You have ALL of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

☐ No daily controller medicines required

☐ Daily controller medicine(s):_____

☐ _____
Take _____ puff(s) or _____ tablet(s) _____ daily.

☐ For asthma with exercise, ADD: _____,
_____ puffs with spacer _____ minutes before exercise

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION!

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

You have ANY of these:
- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ _____ inhaler _____ mcg
Take _____ puffs every _____ hours, *if needed*. Always use a spacer, some children may need a mask.

☐ _____ nebulizer _____ mg /_____ ml
Take a _____ nebulizer treatment every _____ hours, *if needed*.

☐ Other _____

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY!

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

You have ANY of these:
- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

☐ _____ inhaler _____ mcg
Take _____ puffs every _____ hours, *if needed*. Always use a spacer, some children may need a mask.

☐ _____ nebulizer _____ mg /_____ ml
Take a _____ nebulizer treatment every _____ hours, *if needed*.

☐ Other _____

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year _____ – _____ .

Signature _____ Date _____

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature _____ Date _____

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

COPY FOR PATIENT

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Attach child's photo

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

˜ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type):_____ Dose: ☐ 0.15 mg ☐ 0.30 mg (weight more than 25 kg)
Antihistamine, by mouth (type and dose): _____
Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

© 2017 American Academy of Pediatrics. All rights reserved. Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor.

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: (___) _____-_____

Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (_ __) _____-_____

Parent/Guardian: _____ Phone: (_ __) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (__ _) _____-_____

Name/Relationship: _____ Phone: (_ __) _____-_____

© 2017 American Academy of Pediatrics. All rights reserved. Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor.

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

❒ Contact school nurse at _____

❒ Call 911 for transport to _____

❒ Notify parent or emergency contact

❒ Administer emergency medications as indicated below

❒ Notify doctor

❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

Copyright 2008 Epilepsy Foundation of America, Inc.

NYC Health Office of School Health

Diabetes Medication Administration Form [Part A]

Provider Medication Order Form | School Year 2023-24

DUE: June 1st. Forms submitted after June 1st may delay processing for new school year.

Please fax all DMAFs to 347-396-8932/8945

Student Last Name:	First Name:	Date of Birth:	☐ Male ☐ Female	**OSIS #**

School ATSDBN / Name:	Address:	Borough:	DOE District:	Grade:	Class:

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

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Non-Type 1/Type 2 Diabetes

☐ Other Diagnosis:_____

Recent A1c

Date_____/_____/_____ Result_____._____%

Orders written will be implemented when submitted and approved. If you wish to delay orders for September 2023 please check here ☐

EMERGENCY ORDERS

Severe Hypoglycemia
Administer Glucagon and CALL 911

Glucagon	GVOKE	Baqsimi	Zegalogue
☐ 1 mg ☐ _____mg SC/IM	☐ 1 mg ☐ _____ mg SC/IM	☐ 3 mg Intranasal	☐ 0.6 mg SC May repeat in 15 min if needed

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN if bG is unknown. Turn onto left side to prevent aspiration. If more than one option is chosen, school staff will use ONE form of available glucagon unless otherwise directed.

Risk for Ketones or Diabetic Ketoacidosis (DKA)

☐ Test ketones if bG > _____ mg/dl or if vomiting, or fever > 100.5 F
OR
☐ Test ketones if bG > _____ mg/dl for the 2nd time that day (at least 2 hrs. apart), or if vomiting or fever > 100.5 F

- If small or trace give water; re-test ketones & bG in 2 hrs or_____ hrs
- If 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 rapid acting insulin.

SKILL LEVEL *(if not complete, will default to nurse-dependent)*

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 calculates and self-administers, under adult supervision

☐ **Independent Student Self carry / Self-administer** (*MUST initial attestation*). I attest that the independent student demonstrated ability to self-administer the prescribed medication (excluding glucagon) effectively during school, field trips and school sponsored events.

_____
Provider Initials

BLOOD GLUCOSE MONITORING [See Part B for CGM readings]

Specify times to test bG in school (must match times for treatment and/or insulin) ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN

Hypoglycemia *Insulin is given before food unless noted here* ☐ Give insulin after ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give Snack before gym

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 min 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 min 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 treat hypoglycemia and then give snack ☐ Pre-gym ☐ PRN

☐ T2DM – no bG monitoring or insulin in school

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

Mid-Range Glycemia *Insulin is given before food unless noted here* ☐ Give insulin after ☐ Breakfast ☐ Lunch ☐ Snack ☐ Give Snack before gym if bG <_____mg/dl

Hyperglycemia *Insulin is given before food unless noted here* ☐ Give insulin after ☐ Breakfast ☐ Lunch ☐ Snack

☐ For bG _____mg/dl pre-gym, NO GYM For bG meter reading "High" use bG of 500 or _____ mg/dl

☐ For bG >_____mg/dl PRN, Give insulin correction dose if > 2 hrs or_____hrs. since last rapid acting insulin

☐ **Check bG or Sensor Glucose (sG) before dismissal** ☐ *Give correction dose pre-meal and carb coverage after meal*

☐ *For sG or bG values <_____mg/dl treat for hypoglycemia if needed, and give_____gm carb snack before dismissed*

☐ *For sG or bG values <_____mg/dl treat for hypoglycemia if needed, and do not send on bus/mass transit, parent to pick up from school.*

INSULIN ORDERS

Insulin Name*

_____

**May substitute Novolog with Humalog/Admelog*

☐ No Insulin in school ☐ No insulin at Snack

Delivery Method

☐ Syringe/Pen ☐ Smart Pen – use pen suggestions

☐ Pump (Brand) _____

For Pumps:

☐ 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

☐ **Activity Mode (HCL pumps):**
Start ____ minutes prior to exercise for ____ minutes duration (DEFAULT 1 hr prior, during, and 2 hrs following exercise)

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 rapid acting insulin at
☐ Breakfast ☐ Lunch ☐ Snack

Correction dose calculated using: ☐ ISF **or** ☐ Sliding Scale

☐ Fixed Dose *(see Other Orders)*

☐ Sliding Scale *(See Part B)*

☐ If gym/recess is immediately following lunch, subtract _____gm carbs from lunch carb calculation.

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 rapid acting insulin by syringe or pen, and notify parents.

☐ For pump failure, only give correction dose if >_____hrs since last rapid acting insulin

Insulin Calculation Directions: *(give number, not range) If only one given, time will be 7am to 4pm if not specified*

Target bG =_____mg/dl (time _____to_____)

Target bG =_____mg/dl (time _____to_____)

Insulin Sensitivity Factor (ISF):

1 unit decreases bG by _____mg/dl

(time _____to_____)

1 unit decreases bG by _____mg/dl

(time_____to_____)

Insulin to Carb Ratio (I:C):

Bkfast OR time_____to_____

1 unit per_____gms carbs

Snack OR time_____to_____

1 unit per_____gms carbs

Lunch OR time_____to_____

1 unit per_____gms carbs

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.

NYC Health Office of School Health

Diabetes Medication Administration Form [Part B]

Provider Medication Order Form | School Year 2023-24

DUE: June 1st. Forms submitted after June 1st may delay processing for new school year.

Please fax all DMAFs to 347-396-8932/8945

Student Last Name	First Name	OSIS #

CONTINUOUS GLUCOSE MONITORING (CGM) ORDERS *[Please see 'Provider Guidelines for DMAF Completion']*

☐ Use CGM readings - For CGM's used to replace finger stick bG readings, only devices FDA approved for use and age may be used within the limits of the manufacturer's protocol.(sG = sensor glucose). You must include name and model of the CGM in use.

Name and Model of CGM:_____

For CGM used for insulin dosing: finger stick bG will be done when: the symptoms don't match the CGM readings; 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)

☐ CGM to be used for insulin dosing and monitoring - **must be FDA approved for use and age**

sG Monitoring Specify times to check sensor reading ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ PRN [*if none checked, will use bG monitoring times]*

For sG <70mg/dL check bG and follow orders on DMAF, unless otherwise ordered below. Use CGM grid below OR ☐ See attached CGM instruction

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 still < 70 mg/dl check bG.
sG 60-70 mg/dl	and ↓, ↓↓,↘ or →	Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.
sG 60-70 mg/dl	and ↑ , ↑↑, or ↗	If symptomatic, treat hypoglycemia per bG hypoglycemia plan; if not symptomatic, recheck in 15-20 minutes. If 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	and ↓, ↓↓	Give 15 gms uncovered carbs. If gym or recess is immediately after lunch, subtract 15 gms of carbs from lunch carb calculation.
sG ≥ 250	Any arrows	Follow bG DMAF orders for treatment and insulin dosing

☐ For student using CGM, wait 2 hours after meal before testing ketones with hyperglycemia.

PARENTAL INPUT INTO INSULIN DOSING

Parent(s)/Guardian(s) (*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 practitioner and in keeping with nursing judgment.

Please select ONE option below

1. ☐ Nurse may adjust calculated dose up or down up to_____ units based on parental input and nursing judgment.

2. ☐ Nurse may adjust calculated dose up by_____% or down by_____% of the prescribed dose based on parental input and nursing judgment.

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

SLIDING SCALE

Do NOT overlap ranges (e.g. enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. Use pre-treatment bG to calculate insulin dose unless other orders.

☐ Lunch
☐ Snack
☐ Breakfast
☐ Correction Dose

bG	Units Insulin	Other Time ____:____	bG	Units Insulin
Zero -		☐ Lunch	Zero -	
-		☐ Snack	-	
-		☐ Breakfast	-	
-		☐ Correction Dose	-	
-			-	
-			-	
-			-	

OPTIONAL ORDERS

☐ Round insulin dosing to nearest whole unit: 0.51-1.50u rounds to 1.00u.
☐ Round insulin dosing to nearest half unit: 0.26-0.75u rounds to 0.50u (must have half unit syringe/pen).

☐ Use sliding scale for correction AND at meals ADD:
_____ units for lunch; _____ units for snack;
_____ units for breakfast
(sliding scale must be marked as correction dose only)

☐ **Long-acting insulin given in school** – Insulin Name: _____

Dose:_____units Time_____or ☐ Lunch

OTHER ORDERS

HOME MEDICATIONS

☐ None

Medication	Dose	Frequency	Time	Route
Insulin				
Other				

ADDITIONAL INFORMATION

Is the child using altered or non-FDA approved equipment? ☐ **Yes** or ☐ **No** *[Please note that New York State Education laws prohibit nurses from managing non-FDA devices. Please provide pump-failure and/or back up orders on DMAF Part A Form.]*

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

Health Care Practitioner LAST	FIRST	SIGNATURE	DATE
PLEASE PRINT check one ☐ MD ☐ DO ☐ NP ☐ PA			

Address STREET	CITY/STATE	ZIP	**Email**

NPI# or NYS License # (Required)	Tel	Fax	**CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.**

DWIGHT SCHOOL

HEMOPHILIA FORM

New York, New Jersey, or Connecticut licensed healthcare provider and Parent/Guardian signature is required

Student Name: _____ Date of Birth: _____ Weight (lbs.): _____

Diagnosis: _____

Medications taken home: _____

Medication to Store at School for Emergency use:	Dose:	Route:	Frequency	Comments

I Approve the "Emergency Action Plan" on page 2 of this form for this Student: _____ (healthcare provider initial here).
Additional Instructions:

HEALTHCARE PROVIDER AUTHORIZATION

Healthcare Provider's Name: _____ License #: _____ NPI #: _____

Address: _____ Phone #: _____ Fax #: _____

Signature: _____ Date: _____

PARENT/GUARDIAN CONSENT AND AUTHORIZATION

I understand that Dwight School personnel do not administer medications without the consent of the parent/guardian.
In the event of an illness/injury during school hours and/or during Dwight School off campus events I authorize Dwight personnel to administer or assist my child in administering the above listed medication.

I authorize the storage and administration of medication as well as the storage and use of the necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication.

I will supply each medication to the school in a properly labeled original container from the pharmacy. The label on the prescription medication will include the name of my child, 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 will be in the manufacturer's original container, with my child's name affixed to that container.

I understand that I must immediately advise Dwight's Health Office and/or the principal and/or his/her designee(s) of any change in the prescription or instructions stated above and submit a new form.

I acknowledge that I am responsible for collecting all medications provided to the Dwight Health Office at the end of the school year and understand that all uncollected medications will be disposed of at the end of the last day of school.

Parent/Guardian's Name: _____

Signature: _____ Date: _____

DWIGHT SCHOOL

HEMOPHILIA FORM

EMERGENCY ACTION PLAN

SITUATION	ACTION
Nosebleed	• Practice universal precautions • Notify Health Office • Have child sit with head upright, leaning slightly forward • Apply continuous pressure to the nose by pinching nose for 20 minutes • Apply ice to bridge of nose while pinching. • Call parent if bleeding does not stop after 20 min. • If bleeding stops within 20 min, call parent to inform of bleeding
Mouth bleed	• Practice universal precautions • Notify Health Office • Apply ice, cold compress to area of injury with continuous firm pressure for 20 min. • Call parent if bleeding does not stop after 20 min. • If bleeding stops within 20 min, call parent to inform of injury and to assess for need of sutures.
Bleeding from cut, scrape, or laceration	• Practice universal precautions • Notify Health Office • Apply pressure and elevate the body part until bleeding stops. If bleeding does not stop within 20 min, call parent and prepare student to be transported to Hospital (activate 911). • Apply sterile bandage or dressing. • Apply ice pack to area over dressing to aid clotting and decrease pain. • If bleeding stops within 20 min, call parent to inform of injury and to assess for need of sutures.
Injury or fall affecting the head, throat, neck, abdomen, back or groin area	• Notify Health Office • Call parent immediately. • Call doctor or hospital/care center if the parent cannot be reached. • Call 911 if parent cannot be reached and there has been an injury to the head, throat, neck, abdomen, back, or groin area within last week and student complains of pain, swelling, or tightness. • Have student rest and keep student calm. • Call 911 if signs of irritability, confusion, drowsiness, trouble breathing, sweating, cold, clammy skin, stiff neck, or seizure activity. • Apply ice to affected area. *Signs and symptoms of internal bleeding:* o Bruising/discoloration/swelling/pain of injured area o Blood in urine (urine may be pink, red, or cola colored) o Vomit or respiratory secretions with red or brown material o Severe headache, irritability, confusion, drowsiness o Trouble swallowing or breathing o Blurred or double vision, vision changes, unequal pupils o Blood in stools (tarry or bloody) o Inability to raise the injured limb o *Note: A slow bleed after trauma may delay symptoms for days.*