

# Your Road Map to Diabetes Medication Administration Record (Part 1)

Ohio Revised Code (3313.713) is the education law that addresses prescriptive medication administration in Ohio schools. This ORC lists authorization requirements for prescription medications which also includes prescriptive medications for diabetic students.

This Road Map to Diabetes Medication Administration Record (Diabetic MAR) will help the physician and parent or guardian to complete the two-paged diabetic medication comprehensive order form.

The Diabetes Medication Administration Record consist of a two pages that may also include other forms including an Diabetic Emergency Action Plan, Individualized Healthcare Plan, Individualized Education Plan (IEP), 504 etc. A photocopy of an original blank Medication Authorization Record is acceptable, but both sides must be completed and signed. The following guide is number/color coded for parents, school staff and prescribers.

Please do your part to ensure that children with diabetes get the medication they need to ensure their full potential as health learners.

<p><b>Parents:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Part 1: Complete <b>Section A</b> and <b>C</b></li> <li><input type="checkbox"/> Part 2: Complete Sections <b>A</b> and <b>C</b></li> <li><input type="checkbox"/> Important Notice: The physician may complete an additional Diabetic Emergency Action Plan and/or the school nurse may complete an Individualized Healthcare Plan for your approval. In addition, the school may complete an IEP, 504 plan as well. This Diabetic MAR is not intended to replace any of these plans.</li> </ul>	<p><b>School Staff:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review parent/guardian and prescriber sections for completeness in all section</li> <li><input type="checkbox"/> Keep extra blank forms available (for mailing or faxing)</li> </ul> <p><b>Prescriber:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fill in the Prescriber's Order Sections 1-8 and <b>Section B</b> (ensure that student's name and address is complete in <b>Section A</b>).</li> <li><input checked="" type="checkbox"/> <b>Important Notice:</b> Complete an additional Diabetic Emergency Action Plan to accompany this Diabetic MAR if needed</li> </ul>
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Diabetes Medication Administration Record (MAR)			
<b>A</b>	Student Name, Sex, Date of Birth, Home Address, Student ID, Grade/Class, Teacher, School	Student Photo	
<b>1</b>	Emergency Situations		
<b>2</b>	Diagnosis and Home Meds		
<b>3</b>	Blood Glucose (bG) Testing		
<b>4</b>	Hypoglycemia		
<b>5</b>	Insulin Orders and Carb Coverage		
<b>6</b>	Insulin Pump Orders		
		<b>7</b>	Sliding Scale
		<b>8</b>	Snack
		<b>B</b>	Prescriber Authorization
		<b>C</b>	Parent/Guardian Authorization

SAMPLE ONLY

# Your Road Map to Diabetes Medication Administration Record (MAR) Part 2

Part 2 of the Diabetes Medication Administration Record must be completed by parents/guardians and school staff.

Please do your part to ensure that children get the medication they need.

## Diabetes Medication Administration Record (MAR)

### Student Information

**A****Parent/Guardian:**

- Complete student information in Section A

### Parent Authorization

**B****Parent/Guardian:**

- Complete Section B to authorize administration of medication(s) at school, in accordance with prescriber orders

### School Staff Only

**C**

- Section C for use by SCHOOL STAFF only.

# Diabetes Medication Administration Record (MAR) Part 1

A completed form must be provided to the school principal and/or nurse before the student may be assisted in their diabetes management at school

Student name	A	<input type="checkbox"/> Male <input type="checkbox"/> Female Date of birth _____	Home address _____	Student ID# _____	Student Photo (Must attach)
Grade/Class		Teacher _____	School _____		

## Medication orders must be completed and signed by prescriber

1	<b>Emergency Situations</b> Severe Hypoglycemia 1. Give glucagon <input type="checkbox"/> 1 mg IM or SQ or <input type="checkbox"/> _____ mg IM or SQ and CALL 911 PRN for unconsciousness, unresponsiveness, seizure, or inability to swallow 2. Turn student onto his/her side in case of nausea or vomiting 3. Stay with student until emergency help arrives (have someone contact parent(s)) 4. When student awakens and is able to swallow, encourage to take small sips of fluid of a carb-containing fluid (fruit juice/regular soda). If tolerated, follow with 15 grams of a carb and fat-containing food (peanut butter/crackers). Check blood glucose every 15 minutes and repeat snacks until BG is above 200mg/dL 5. Other _____	<b>Risk for Diabetic Ketoacidosis (DKA)</b> 1. <input type="checkbox"/> Ketones: Test ketones if hyperglycemic*, ill, vomiting, or fever >100.5 oral If small or trace, give unlimited water and restroom pass. Re-test ketones and BG in _____ hours. If initial or retest ketones are moderate or large, give unlimited water and restroom pass and: <input type="checkbox"/> Call parent <input type="checkbox"/> and/or MD <input type="checkbox"/> No gym/recess <input type="checkbox"/> If vomiting, unable to take by mouth, and MD not available. Call 911 <input type="checkbox"/> Give insulin bolus, if ordered			
2	<b>Diagnosis and Home Meds</b> <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Other _____	<b>Home Medications (Name, dose, frequency, and time)</b> Insulin _____ Other home meds _____			
3	<b>Blood Glucose (BG) Testing</b> <input type="checkbox"/> May check BG without supervision <input type="checkbox"/> May check BG with supervision <input type="checkbox"/> Must have school personnel check BG <input type="checkbox"/> Test BG prior to eating meals/snacks that contain carbohydrates <input type="checkbox"/> Test BG for symptoms/signs of a high or low BG <input type="checkbox"/> Test BG if student is ill				
4	<b>Hypoglycemia</b> <input type="checkbox"/> If the BG is less than <input type="checkbox"/> _____ or <input type="checkbox"/> 70 mg/dL (children 6 years and older) or less than <input type="checkbox"/> _____ or <input type="checkbox"/> 80 mg/dL (children less than 6 years old) and the child can safely consume food/drink, give 15 grams of fast-acting carbs (4 oz juice or regular pop, 3-4 glucose tablets or 5-8 lifesavers) <input type="checkbox"/> Retest BG in 15 minutes. Give additional 15 grams until BG is greater than 70 mg/dL (children 6 years and older) or greater than 80 mg/dL (children less than 6 years old) <input type="checkbox"/> If the low BG occurs at meal or snack time, treat the low BG as above and then give the usual insulin dose <input type="checkbox"/> If unable to test BG, but child is symptomatic of low BG, treat as noted above <input type="checkbox"/> Contact the parent(s) if the child required two or more carb treatments for a low BG or if the BG was less than 50 mg/dL <input type="checkbox"/> If meal more than one hour away, give additional _____ gm of snack with protein <input type="checkbox"/> If participating in exercise, give additional _____ gm of snack with protein				
5	<b>Insulin Orders and Carb Coverage</b> <b>Check one box only</b> <input type="checkbox"/> Carb coverage <input type="checkbox"/> Carb coverage plus correction when BG > target BG or sliding scale <input type="checkbox"/> Sliding scale <input type="checkbox"/> No insulin at school — glucose monitoring <b>ONLY</b>	<b>Name of Insulin</b> <input type="checkbox"/> insulin lispro (Humalog*) <input type="checkbox"/> insulin aspart (Novolog*) <input type="checkbox"/> insulin glulisine (Apidra*) <input type="checkbox"/> Other _____ <input type="checkbox"/> Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Pump	<b>Target Blood Glucose (BG) = _____ mg/dL</b> Insulin: Carb Ratio: (I:C) For breakfast _____ of insulin _____ gm carb For lunch _____ of insulin _____ gm carb For dinner _____ of insulin _____ gm carb		
6	<b>Insulin Pump Orders</b> (brand/model) _____ <input type="checkbox"/> In school Basal Rate(s) _____ units/hour <input type="checkbox"/> Gym or temp. _____ % basal rate for _____ hours <input type="checkbox"/> Disconnect pump for gym	<b>For Pump</b> <input type="checkbox"/> Follow pump recommendation for bolus dose (if not using pump recommendation round DOWN the dose, down to nearest 0.1 unit) <input type="checkbox"/> For BG > _____ mg/dL that has not decreased _____ hours after correction consider pump failure Notify parent <input type="checkbox"/> For suspected pump failure: DISCONNECT pump and give insulin by syringe or pen			

# Diabetes Medication Administration Record (MAR) Part 1

Student name		Grade/Class	
<b>A</b>	<p><b>Sliding Scale</b>    <input type="checkbox"/> Not Applicable    <input type="checkbox"/> Pre lunch</p> <p>Name of Insulin _____    bG Range _____ to _____    Insulin Units _____    bG Range _____ to _____    Other time _____    Insulin Units _____</p> <p>Please do NOT overlap ranges (e.g. 100-200, 200-300, etc.)    bG Range _____ to _____    Insulin Units _____    bG Range _____ to _____    Other time _____    Insulin Units _____</p> <p>If ranges overlap, the lower dose will be given    bG Range _____ to _____    Insulin Units _____    bG Range _____ to _____    Other time _____    Insulin Units _____</p>		
<b>7</b>	<p><b>Snack</b>    Time of Day _____    No. of Carbs Allowed _____    Food Choice _____</p> <p><input type="checkbox"/> Student may carry and self administer snacks</p> <p>Special Instructions _____</p> <p>Possible severe adverse reaction _____</p> <p><input type="checkbox"/> See Emergency Action Plan</p>		
<b>B</b>	<p><b>Prescriber Authorization</b></p> <p>Prescriber name (print) _____    Prescriber address _____    Prescriber Emergency phone _____</p> <p>Prescriber signature _____    Fax _____</p>		
<b>C</b>	<p><b>PARENT AUTHORIZATION</b></p> <p><input checked="" type="checkbox"/> I authorize an employee of the school board to administer the above medication.</p> <p><input checked="" type="checkbox"/> I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.</p> <p><input checked="" type="checkbox"/> I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist should a question come up about the medication.</p> <p><input checked="" type="checkbox"/> Medication form must be received by the principal, his/her designee, or the school nurse.</p> <p><input checked="" type="checkbox"/> I understand that the medication must be in the <b>original</b> container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.</p>		
Parent/Guardian signature		Date	<p>#1 contact phone ( )</p> <p>#2 contact phone ( )</p>

# Diabetic Medication Administration Record (MAR) Part 2

Prescriber order(s) and signature required on page 2 of the Diabetic Medication Administration Record (Part 1). A completed form must be provided to the school principal and/or nurse before prescription medication may be administered in school

## Student Information

A

Student name	Date of birth
Student address	Grade/Classroom

## Parent Authorization

B

<input checked="" type="checkbox"/> I authorize a designated employee of the school board to administer the prescriber's medication as ordered for my child			
<input checked="" type="checkbox"/> I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed			
<input checked="" type="checkbox"/> I also authorize the licensed health care professional to talk with the prescriber or pharmacist should a question come up about the medication			
<input checked="" type="checkbox"/> Medication and medication form must be received by the principal, his/her designee, or the school nurse			
<input checked="" type="checkbox"/> I Understand that the medication must be in the <b>original container</b> and be <b>properly labeled</b> with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration when appropriate			
<input checked="" type="checkbox"/> I agree that it is important to keep diabetic medication and supplies at the school's designated location			
<input checked="" type="checkbox"/> I understand I must come into the school office/clinic when my child's medication is discontinued by the prescriber or at the end of the school year, or medication will be disposed of one week post-discontinuation orders or school year end			
Parent/Guardian signature	Date	#1 Contact Phone	#2 Contact Phone

## Do not write below (For school staff only)

C

Reviewed by	Title/Position	Date
Comments		