Office of
School Health

استمارة إعطاء دواء مرض السكري
استمارة طلب الدواء من مقدّم الخدمة | للعام الدراسي 2025-2026
ترجو إرسال جميع استمارات إعطاء دواء مرض السكري (DMAF) بالفاكس على الرقم 8932- 396-347،
أو 8945-396-347.

الاسم الأخير **للتلميذ(ة)**: _____ الاسم الأول: _____ تاريخ الميلاد: _____ الجنس ☐ ذكر ☐ أنثى رقم تعريف التلميذ(ة) (OSIS): _____

رقم (ATSDBN)/ اسم **المدرسة**: _____ العنوان:_____ الحي:_____ المنطقة التعليمية: _____الصف/ الفصل: _____

Change Blood Glucose (bG)/Sensor Glucose (sG) Monitoring Times:

☐ PRN ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ Dismissal
☐ Discontinue all bG/sG monitoring at school, including PRN instructions

Change CGM Brand/Model: Name: _____ ☐ Use attached CGM grid

Change Insulin Dosing:

☐ Discontinue all rapid acting insulin in school, including instructions to give correction doses PRN or in the setting of ketosis
☐ Discontinue sliding scale(s), use ratios below

Change target blood glucose to:

____ mg/dl from _____ AM/PM to _____ AM/PM

____ mg/dl from _____ AM/PM to _____ AM/PM

Change insulin sensitivity factor (ISF) to:

1: ____ mg/dl from _____ AM/PM to _____ AM/PM

1: ____ mg/dl from _____ AM/PM to _____ AM/PM

Change insulin to carbohydrate ratio (I:C) to:

1: ____ g from ____ AM/PM until _____ AM/PM or at ☐ Breakfast ☐ Lunch ☐ Snack

1: ____ g from ____ AM/PM until _____ AM/PM or at ☐ Breakfast ☐ Lunch ☐ Snack

Change long-acting insulin at school: Name: _____ Dose: ____ units Time: _____ ***OR*** pre-lunch

Other Orders

_____

_____

_____

_____

_____

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.