Bureau
de la santé scolaire

Formulaire d'administration de médicaments contre le diabète
Formulaire d'ordonnance médicale du prestataire | Année scolaire 2025-2026
Faxez tous les DMAF au 347-396-8932/8945

Nom de famille de **l'élève** : _____ Prénom : _____ Date de naissance : _____ Sexe ☐ M ☐ F NºOSIS : _____
DBN ATS/nom de l'**école** : _____ Adresse :_____ Borough :_____ District : _____Grade/classe : _____

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.