學校健康辦公室

糖尿病藥物施用表

保健提供者囑咐的藥物用法表 | **2025-26**學年

請將所有的糖尿病藥物施用表(DMAF) 傳真到347-396-8932/8945。

學生姓氏：_____ **名字：**_____ **出生日期：**_____ **性別** ☐ **男** ☐ **女** **OSIS#：**_____

學校ATSDBN/名稱：_____ 地址：_____ 行政區：_____ 學區：_____ 年級/班級：_____

These orders must be submitted with Parts A and B of the SY 25-26 DMAF. The iLet pump does not deliver correction dose boluses or use carb ratios. If you would like the school nurse to use the iLet pump, you must provide carbohydrate ranges for "less", "usual", and "more" carbohydrates ***or*** select one option the nurse should use for each meal.

GLUCOSE TARGET

Usual (120 mg/dl) or ☐ Lower (110 mg/dl) ☐ Higher (130 mg/dl)

MEAL ANNOUNCEMENTS

☐ Minimum carbohydrate content to announce meal or snack: 15 g or _____ g carbs

☐ Use selected meal size regardless of how many carbs the student is eating

Meal Type	Meal Size Less*	Usual	More
Breakfast	☐	☐	☐
Lunch	☐	☐	☐

** If the "Less" option is not available, do not announce the meal/snack*

OR

☐ **Select meal size based on carbohydrate content** in meal. You may use large ranges, e.g., 15-100 g carbs

Meal Type	Meal Size Carbohydrate Range (g) Less*	Usual	More
Breakfast	–	–	–
Lunch	–	–	–

Announce snacks as:

☐ "Less" lunch
☐ "Less" breakfast
☐ Closest meal in time
☐ Closest meal based on usual carb content (must give range of carbs above)
☐ Other: _____
☐ Do not announce snacks

General iLet Insulin Pump Orders

Do not announce meals more than 15 min or _____ min prior to eating.

Do not announce meals if it has been more than 30 min or _____ min since the student started eating.

☐ If the student eats more carbohydrates after a meal announcement, announce again for the additional carbs. Only consider the amount of additional carbs when choosing the additional meal size; do not include carbs that were already announced.

ACTIVITY PARAMETERS

☐ Disconnect pump 60 min or _____ min before starting activity and reconnect immediately or _____ min after activity
  ☐ If lunch is immediately before activity, do not disconnect pump until activity starts
  ☐ **After** disconnecting pump for activity, give ____ g of uncovered carbs pre-activity if bG < _____ mg/dl
☐ Do not disconnect pump or give uncovered carbohydrates prior to activity

PUMP FAILURE ORDERS

In the event of iLet pump failure, contact parent/endocrinologist/provider for dosing instructions or use the following ratios to deliver insulin via syringe/pen.

Target bG = _____ mg/dl
ISF 1:_____ mg/dl
I:C 1:_____ g

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