



Прізвище учня: _____ Ім'я: _____ Дата народження: _____ Стать ☐ Ч ☐ Ж Номер OSIS: _____
Номер школи в ATSDBN / назва: _____ Адреса: _____ Район: _____ Округ: _____ Клас/група: _____

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.