

Diabetga qarshi dorilarni qabul qilish shakli 2025-2026 o'quv yili uchun sog'liqni saqlash provayderlaridan dorilarga ko'rsatma shakli Iltimos, Shakl uchun barcha so'rovlarni 347-396-8932/8945 raqamiga faks orqali yuboring.

O'quvchining Familiyasi:		Ismi:		Tug'ilgan sanasi:			
Maktab ATSDBN / Nomi:		Manzil:		Shaharcha:	Tuman:	Sinf:	
Ohanana Bland Olivana	(h 0) (0 a m a a m (Oliverse (a O.) Marrit	! T !				
Change Blood Glucose	(DG)/Sensor (Siucose (SG) Monito	oring Times:				
□ PRN □ Breakfast		•					
☐ Discontinue all bG/sG	monitoring at s	school, including PRN	l instructions				
Change CGM Brand/Mo	odel: Name: _		□ Use att	ached CGM grid			
Change Insulin Dosing:	<u> </u>						
□ Discontinue all rapid a □ Discontinue sliding sca	•	•	ructions to give o	correction doses PRN	or in the setting	of ketosis	
Change target blood gl	ucose to:						
mg/dl from <i>A</i>	AM/PM to	_ AM/PM					
mg/dl from A	AM/PM to	_ AM/PM					
Change insulin sensitiv	vity factor (ISF) to:					
1: mg/dl from	_ AM/PM to	AM/PM					
1: mg/dl from	_ AM/PM to	AM/PM					
Change insulin to carbo	ohydrate ratio	(I:C) to:					
1: g from AM/	PM until	_AM/PM or at □ Bre	akfast □ Lunch [□ Snack			
1: g from AM/	PM until	AM/PM or at □ Bre	akfast □ Lunch [□ Snack			
Change long-acting ins	ulin at school	: Name:		_ Dose: units Tir	ne: <i>O</i>	R pre-lunch	
			Other Orders				
			onder Orders				
	By signing t	this form I cortify that I have	discussed these order	ers with the parent(s)/quardia	in/s)		
	by signing t	mis form, i certify that i have	e discussed triese orde	ers with the parent(s)/guardia	n(s).		
Health Care Provider (PLEASE PRINT)							
Last Name:		_ First Name (Print):		Signature:	Date: _		
Credentials: ☐ MD		□ PA					
Address:		City/State:	ZIP: Tel:				
N I S I ICHOSH # OF NPI # IRC	econtrects:		1 🖭	HAX.			

CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.