Oficina de Salud Escolar

Formulario de administración de medicamentos para la diabetes

Formulario de orden de medicamentos del proveedor de servicios médicos | Año escolar 2025-2026

Envíe los formularios DMAF para la diabetes por fax al 347-396-8932/8945

Las órdenes médicas escritas se implementarán una vez recibidas y aprobadas. Si desea que se comience a implementar una orden médica en septiembre de 2025, marque esta casilla ☐

Apellido del **estudiante**: ____________________ Nombre: ________________________ Fecha de nacimiento: ____________ Sexo ☐ M ☐ F Número OSIS: _______

Nombre/ATSDBN de la **escuela**: _____________________ Dirección:_______________________ Condado:____________ Distrito: _______Grado/Clase: ________

HEALTH CARE PRACTITIONER COMPLETES BELOW *[Please see 'Provider Guidelines for DMAF Completion']*

Section A: Diagnosis

A1. Diagnosis
Diabetes Mellitus ☐ Type 1 ☐ Type 2 ☐ Other:______________ Dx Date ____/____/______

A2. Recent A1c
Date ____/____/______ Result: _____ . _____ (%)

SECTION B: Emergency Orders

B1. Severe Hypoglycemia
ADMINISTER GLUCAGON AND CALL 911

Glucagon	GVOKE	Baqsimi	Zegalogue
☐ 1 mg SC/IM	☐ 1 mg SC/IM	☐ 3 mg Intranasal	☐ 0.6 mg SC
☐ 0.5 mg SC/IM	☐ 0.5 mg SC/IM		May repeat in 15 min PRN

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN IF bG is Unknown. Turn onto left side to prevent aspiration and call 911 If more than one option is chosen, school staff will use ONE form of available glucagon unless otherwise directed.

B1. Risk for Diabetic Ketoacidosis (DKA)
CALL 911 IF POSITIVE KETONES AND VOMITING, UNABLE TO TAKE PO, ALTERNED MENTAL STATUS, OR BREATHING CHANGES

Test ketones if any of the following:
- vomiting
- fever ≥ 100.5 F
- bG > _____ mg/dl for the ☐ FIRST ***OR*** ☐ SECOND time that day, ≥ 2 hrs apart

If ketones small or trace, give water, re-test ketones & bG in 2 or ____ hrs

If ketones moderate or large, give water, **call**
☐ Give insulin correction dose if ≥ 2 hrs or ____ hrs since last rapid acting insulin
☐ NO GYM

SECTION C: Glucose Monitoring

C1. Glucose Monitoring Times
☐ PRN
☐ Breakfast
☐ Lunch
☐ Snack
☐ Gym
☐ Dismissal
☐ No bG monitoring

C2. Continuous Glucose Monitor Use *(Must complete Section G)*
☐ Use CGM readings for glucose monitoring
☐ Use CGM readings for insulin dosing
For CGMs to be used for glucose monitoring and/or insulin dosing, devices must be FDA approved for use and age and used within the limits of the manufacturer's protocol.

SECTION D: Skill Level *(If incomplete or attestation not initiated, default is nurse dependent)*

D.1 Glucose Monitoring	D2. Insulin Calculation & Administration	
☐	☐	**Nurse dependent:** Nurse or trained staff must perform
☐	☐	**Supervised:** Student to perform with adult supervision
☐	☐	**Independent:** Student carries supplies & self-administers

Skill Level: Skills include finger sticks, glucometer and/or CGM use, insulin dose calculation, and insulin administration only nurses or supervised/independent students may calculate/administer insulin

FOR INDEPENDENT MEDICATION ADMINISTRATION: I attest

____
Provider Initials

SECTION E: Glucose Monitoring Parameters

E1. Hypoglycemia (*Provide additional hypoglycemia instructions in Section I: Other Orders*)

E1a. Oral Hypoglycemia Treatment
☐ For bG < 70 mg/dl or <_____ mg/dl, give 15 g or ____ g rapid carbs at PRN and ☐Breakfast ☐Lunch ☐Snack ☐Gym ☐Dismissal
Recheck bG in 15 or ____ min until bG > 70 mg/dl or _____ mg/dl

☐ For bG < _____ mg/dl, give ____ g rapid carbs at ☐PRN ☐Breakfast ☐Lunch ☐Snack ☐Gym ☐Dismissal
Recheck bG in 15 min or ____ min until bG > _____ mg/dl

15 g rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz juice

E1b. Pre-Gym Hypoglycemia Orders
☐ For bG < _____ mg/dl, no gym
☐ For bG < _____ mg/dl, treat hypoglycemia then give uncovered snack*
☐ For bG < _____ mg/dl, give uncovered snack*

E1c. Pre-Dismissal Hypoglycemia Orders
☐ For bG < _____ mg/dl, treat hypoglycemia PRN, and give ____ g carb snack before dismissed
☐ For bG < _____ mg/dl, treat hypoglycemia PRN, call parent to pick up

*Snacks provided by staff will be between 15-25 g carbs unless otherwise specified in Section I: Other Orders

E2. Hyperglycemia
☐ For bG > ______ mg/dl pre-gym, ☐ no gym and ☐ check ketones (no gym applies regardless of ketones, for ketone parameters, see Section B2)
☐ For bG > ______ mg/dl PRN, give insulin correction if ≥ 2 hrs or ____ hrs since last rapid acting insulin

bG "HI" reading = 500 mg/dl or _________ mg/dl

SECTION F: Insulin Orders

F1. Insulin Name

_____________________ ☐ No insulin in school
** May substitute Novolog with Admelog/Humalog*

F2. Insulin Delivery Method
☐ Syringe/Pen ☐ Smart Pen - use pen suggestions
☐ Pump (Brand) **If left blank, will use syringe/pen*

____
**For iLet, must complete iLet Pump Orders Form*

F3. Insulin Pump Orders
☐ Student on FDA approved hybrid closed loop pump – basal rate variable per pump
☐ Follow pump recommendations for bolus doses
☐ Suspend/disconnect pump for hypoglycemia not responding to treatment for _____ min
☐ Suspend/disconnect pump for gym
☐ Activity Mode: Start 60 min or ____ min prior to exercise until 120 min or ____ min after exercise

F4. Concern for Pump Failure/Pump Dislodgement
☐ For bG > _____ mg/dl that has not decreased in ____ hrs after correction, consider pump failure and notify parents
☐ For suspected pump failure/dislodgement, SUSPEND pump and give rapid acting insulin by syringe/pen
☐ For pump failure/dislodgement, only give correction dose if > ____ hrs since last rapid acting insulin
☐ In the setting of pump failure/dislodgement, do not use the pump to calculate insulin correction doses

F5. Insulin Calculation Methods
F5a. Correction Dose Using: ☐ ISF ☐ Sliding Scale
F5b. Carb Coverage Using: ☐ I:C ☐ Sliding Scale ☐ Fixed Dose
F5c. Insulin Dosing for Meals:

Insulin Dose	Meal: Breakfast	Lunch	Snack
Carb Coverage Dose	☐	☐	☐
Correction Dose	☐	☐	☐

When carb coverage and correction doses are given at the same time, correction dose will be added when bG > target ***and*** ≥ 2 hrs or ____ hrs since last rapid acting insulin unless otherwise specified

F5d. Exceptions to Pre-Food Insulin Administration
☐ If bG> _____ mg/dl, give correction dose pre-meal and carb coverage after meal
☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

Carb Coverage using I:C

$\frac{\text{\# g carb in meal}}{\text{I:C}}$ = X units insulin

Correction using ISF

$\frac{\text{bG – target bG}}{\text{ISF}}$ = Y units insulin

Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have ½ unit marks unless otherwise instructed by PCP/Endocrinologist. **Round DOWN** to nearest 0.1 unit for pumps unless following pump recommendations or PCP/Endocrinologist orders.

F6. Insulin Dose Calculation Ratios
Times will be 7am – 4pm if not specified

F6a. Target bG
_____ mg/dl from time ________ to ________

_____ mg/dl from time ________ to ________

F6b. Insulin Sensitivity Factor (ISF)

1 unit decreases bG by:

_____ mg/dl from time ________ to ________

_____ mg/dl from time ________ to ________

F6c. Insulin:Carb Ratio (I:C)
Time ________ to ________ ***OR*** Breakfast

1 unit per ____ g carbs

Time ________ to ________ ***OR*** Lunch

1 unit per ____ g carbs

Time ________ to ________ ***OR*** Snack

1 unit per ____ g carbs

☐ If gym/recess is immediately following meal, subtract ____ g carbs from meal carb calculation

SECTION F: Insulin Orders (Continued)

F7. Sliding Scales (*Provide additional sliding scales in Section I: Other Orders*)
Do **NOT** overlap ranges (e.g., enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. You must provide a range from 0 to "high" bG, which is 500 mg/dl unless otherwise specified in Section E2: Hyperglycemia. Use pre-treatment bG to calculate insulin dose unless specified in Section I: Other Orders.

F7a. Correction Dose

bG (mg/dl)		Units
Zero	-	0
	-	
	-	
	-	
	-	
	-	
	-	

F7b. Carb Coverage *PLUS* Correction Dose

bG (mg/dl)		Units	Use For:
Zero	-	0	☐ Breakfast
	-		☐ Lunch
	-		☐ Snack
	-		☐ See attached
	-		
	-		
	-		

F8. Fixed Dosing for Carb Coverage
Correct bG using method in Section F5a: Correction Dose and for carb coverage ADD:
☐ ____ units for breakfast
☐ ____ units for lunch
☐ ____ units for snack

F9. Alternate Rounding Instructions
☐ Round insulin dosing to nearest whole unit: 0.50-1.49u rounds to 1u
☐ For half unit pen/syringe, round insulin dosing to nearest half unit: 0.25-0.74u rounds to 0.5u

F10. Long-Acting Insulin
☐ Give long-acting insulin at school
Name: _____________________
Dose: ____ units
Time: ________ ***OR*** pre-lunch
Long-acting insulin may be given at the same time as rapid-acting insulin at a different

SECTION G: Continuous Glucose Monitoring (CGM) Orders *[Please see 'Provider Guidelines for DMAF Completion']*

G1. Name and Model of CGM: _____________________

For CGMs to be used for glucose monitoring and/or insulin dosing, devices must be FDA approved for use and age and used within the limits of the manufacturer's protocol and in accordance with manufacturer's instructions. For CGM used for insulin dosing, finger stick bG will be done when symptoms don't match the CGM readings or if there is some reason to doubt the sensor (i.e. for readings
< 70 mg/dl or sensor does not show both arrows and numbers). For sG < 70mg/dl, check bG and follow hypoglycemia orders on DMAF, unless otherwise ordered below.

G2. CGM Instructions: Use CGM grid below ***OR*** ☐ see attached CGM instructions.

CGM Reading	**Arrows**	**Action** ☐ **use < 80 mg/dl instead of < 70 mg/dl for grid action plan**
sG < 60 mg/dl	Any arrows	Treat hypoglycemia per bG hypoglycemia plan. Recheck in 15-20 min. If sG still < 70 mg/dl, check bG.
sG 60-69 mg/dl	↓, ↓↓, ↘ or →	Treat hypoglycemia per bG hypoglycemia plan. Recheck in 15-20 min. If sG still < 70 mg/dl, check bG.
sG 60-69 mg/dl	↑, ↑↑, or ↗	If symptomatic, treat hypoglycemia per bG hypoglycemia plan. If asymptomatic, recheck in 15-20 min. If sG still <70 mg/dl, check bG.
sG ≥ 70 mg/dl	Any arrows	Follow bG DMAF orders for insulin dosing.
sG ≤ 120 mg/dl pre-gym or recess	↓, ↓↓	Give 15 g uncovered carbs. If gym or recess is immediately after lunch, subtract 15 g of carbs from lunch carb calculation.
sG ≥ 250 mg/dl	Any arrows	Follow bG DMAF orders for treatment and insulin dosing.
☐ For student using CGM, wait 2 hours after a meal before testing for ketones with hyperglycemia		

SECTION H: Parental Input into Dosing
Parent(s)/Guardian(s) (**MUST GIVE NAME**), ___________________________________, may provide the nurse with information relevant to insulin dosing, including dosing recommendations. Taking the parent's input into account, the nurse will determine the insulin dose within the range ordered by the health care provider and in keeping with nursing judgement.

SELECT ONE
☐ Nurse may adjust calculated dose up or down up to ____ units based on parental input and nursing judgment
☐ Nurse may adjust calculated dose up by ____ % or down by ____ % of the prescribed dose based on parental input and nursing judgement.

MUST COMPLETE: Health care provider can be reached for urgent dosing orders at (________) ________- _______________. If the parent requests a similar adjustment for > 2 days in a row, the nurse will contact the health care provider to see if the school orders need to be revised.

SECTION I: Other Orders

____
____
____
____

SECTION J: Home Medications

Medication	Dose	Route	Frequency	Time

SECTION K: Additional Information
Is the child using altered or non-FDA approved equipment? ☐ **Yes** ☐ **No** [*Please note that New York State Education laws prohibit nurses from managing non-FDA approved devices. For nurse to administer insulin at school, you must provide pump failure and/or back up orders on DMAF page 1.*]

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.

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Formulario de orden de medicamentos del proveedor de servicios médicos | Año escolar 2025-2026
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Apellido del **estudiante:** ____________________ Nombre: ________________________ Fecha de nacimiento: ____________ Sexo ☐ M ☐ F Número OSIS: _______
Nombre/ATSDBN de la **escuela**: _____________________ Dirección:_______________________ Condado:_____________ Distrito: _______Grado/Clase: ________

PADRES Y TUTORES: LEAN, LLENEN Y FIRMEN. AL FIRMAR ABAJO ACEPTO LO SIGUIENTE:

1. Autorizo a la enfermería escolar/Centros de Salud Escolares (*School Based Health Centers*, SBHC) a administrar a mi hijo el medicamento que se le ha recetado. También autorizo a la enfermería escolar/personal capacitado/proveedor de los SBHC a que comprueben el nivel de azúcar en la sangre y a que le proporcionen tratamiento en caso de que presente niveles bajos de azúcar según las indicaciones y el nivel de destreza necesario determinado por el médico de mi hijo. La escuela podrá llevar a cabo estas prácticas en la sede escolar o durante las excursiones escolares.
2. También doy mi autorización para que se utilicen los equipos necesarios para guardar y usar los medicamentos de mi hijo en la escuela.
3. Entiendo que:
   - Tengo que proporcionarle a la enfermería escolar/proveedor de los SBHC los medicamentos, *snacks*, equipos y suministros para mi hijo y reemplazar dichos medicamentos, *snacks*, equipos y suministros cuando sea necesario. La Oficina de Salud Escolar (*Office of School Health*, OSH) recomienda que se utilicen lancetas de seguridad y otros dispositivos con agujas de seguridad y accesorios para verificar los niveles de azúcar en la sangre de mi hijo y administrarle insulina.
   - Autorizo a mi hijo a portar y guardar sus medicamentos/suministros en la escuela y en las excursiones según se describe en su reunión de la Sección 504.
   - Todos los medicamentos con y sin receta que entregue a la escuela deben ser nuevos y estar sin abrir en su frasco o caja original. Proporcionaré a la escuela medicamentos que no estén vencidos para que mi hijo los tome durante el día escolar.
     - Los medicamentos con receta deben tener la etiqueta original de la farmacia en la caja o el frasco. Esta etiqueta deberá incluir: **1)** nombre de mi hijo, **2)** nombre y teléfono de la farmacia, **3)** nombre del médico de mi hijo, **4)** fecha, **5)** número de reposiciones de la receta, **6)** nombre del medicamento, **7)** dosis, **8)** cuándo tomar el medicamento, **9)** cómo tomar el medicamento y **10)** cualquier otra indicación.
   - Debo avisar **inmediatamente** a la enfermería escolar/SBHC si se produce algún cambio respecto al medicamento de mi hijo o a las indicaciones del médico.
   - La OSH y sus representantes que participan en la prestación de los servicios de salud arriba mencionados confían en que la información proporcionada en este formulario es correcta.
   - Con mi firma en este Formulario de administración de medicamentos (*Medication Administration Form*, MAF) autorizo a la OSH a ofrecerle servicios de salud relacionados con la diabetes a mi hijo. Estos servicios pueden incluir, entre otros, una evaluación clínica o un examen físico de un médico o personal de enfermería de la OSH.
   - La orden de medicamentos de este formulario MAF vence al finalizar el año escolar de mi hijo que podría incluir el programa de verano, o cuando yo le entregue a la enfermería escolar/proveedor de los SBHC un nuevo formulario MAF (lo que suceda primero). Cuando esta orden de medicamentos venza, proporcionaré a la enfermería escolar/proveedor de los SBHC un nuevo formulario MAF llenado por el médico de mi hijo.
   - La OSH y el Departamento de Educación (DOE) garantizan que mi hijo pueda medir su nivel de azúcar en sangre de forma segura.
   - Este formulario representa mi autorización y solicitud para los servicios para diabetes aquí descritos y puede ser enviado directamente a la OSH. Este formulario no constituye un acuerdo de la OSH para proporcionar los servicios solicitados. Si la OSH decide proporcionar estos servicios, es posible que mi hijo también necesite un Plan de Adaptaciones para Estudiantes. La escuela completará este plan.
   - Para proporcionarle tratamiento o cuidados a mi hijo, la OSH también podrá obtener cualquier información que estime necesaria sobre su problema médico, medicamentos o tratamiento. La OSH podrá obtener dicha información a través de cualquier médico, enfermero o farmacéutico que le haya prestado servicios de salud a mi hijo.

NOTA: Durante las excursiones y las actividades escolares fuera de la escuela, es preferible que usted envíe los medicamentos y equipos para su hijo.

Línea directa de la OSH para padres que tengan preguntas sobre el Formulario de administración de medicamentos para la diabetes (*Diabetes Medication Administration Form*, DMAF): 718-786-4933

PARA LA AUTOADMINISTRACIÓN DE MEDICAMENTOS O PROCEDIMIENTOS (SOLO PARA ESTUDIANTES INDEPENDIENTES):

- Certifico y confirmo que mi hijo está perfectamente capacitado y puede tomarse los medicamentos o realizarse los procedimientos sin supervisión. Doy mi autorización para que mi hijo porte, guarde y se tome en la escuela y durante excursiones el medicamento recetado. Soy responsable de entregarle a mi hijo dicho medicamento, ya sea en frascos o cajas, como se describió anteriormente. También me hago responsable de supervisar el uso que mi hijo le dé al medicamento y de las consecuencias de dicho uso en la escuela. La enfermería escolar o proveedores de los SBHC confirmarán que mi hijo es capaz de portar y tomarse el medicamento por sí solo. También accedo a entregarle a la escuela medicamento de reserva en cajas o frascos con etiquetas claramente visibles.
- Autorizo a que la enfermería escolar o el personal escolar capacitado le administre glucagón a mi hijo si así lo prescribe su proveedor de atención médica, en caso de que mi hijo no pueda temporalmente llevarlo consigo o suministrárselo por sí solo.

LOS PADRES Y TUTORES DEBEN FIRMAR A CONTINUACIÓN

Nombre del padre o tutor en letra imprenta:__________________________ **Firma del padre o tutor para las partes A y B:** _________________________ Fecha: _________

Dirección del padre o tutor: ___________________________________ Correo electrónico del padre o tutor: ____

Números de contactos para emergencias Teléfono del contacto: ________________ Teléfono del hogar: _____________________ Celular: ____________________

Nombre del contacto alternativo para emergencias: ______________________________ Parentesco con el estudiante:______________ Teléfono: ___________________

Apellido del **estudiante**: ____________________ Nombre: ________________________ Fecha de nacimiento: ____________ Sexo ☐ M ☐ F Número OSIS: _______
Nombre/ATSDBN de la **escuela**: ______________________ Dirección:________________________ Condado:_____________ Distrito: _______Grado/Clase: ________

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: ______________________

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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: ______________________

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