Salomatlik maktabi idorasi

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.

Yozma ko'rsatmalar topshirilgan va tasdiqlangandan keyin bajariladi. Agar siz 2025-yil sentabrida ko'rsatmani amalga oshirishni boshlamoqchi bo'lsangiz, bu yerni tekshiring ☐

O'quvchining Familiyasi: _____ Ismi: _____ Tug'ilgan sanasi: _____ Jinsi ☐ E ☐ A OSIS#: _____

Maktab ATSDBN / Nomi: _____ Manzil:_____ Shaharcha:_____ Tuman: _____ Sinf: _____

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
☐	☐
☐	☐
☐	☐

_____
Provider Initials

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

Nurse dependent: Nurse or trained staff must perform

Supervised: Student to perform with adult supervision

Independent: Student carries supplies & self-administers

FOR INDEPENDENT MEDICATION ADMINISTRATION: I attest

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

Salomatlik maktabi idorasi

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O'quvchining Familiyasi: _____ Ismi: _____ Tug'ilgan sanasi: _____ OSIS#: _____

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.

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

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
	-		
	-		
	-		

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.

Salomatlik maktabi idorasi

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O'quvchining Familiyasi: _____ Ismi: _____ Tug'ilgan sanasi: _____ Jinsi ☐ E ☐ A OSIS#: _____

Maktab ATSDBN / Nomi: _____ Manzil:_____ Shaharcha:_____ Tuman: _____ Sinf: _____

OTA-ONALAR VA VASIYLAR: O'QIDIM, BAJARDIM, VA IMZO CHEKDIM. IMZO CHEKISH ORQALI MEN QUYIDAGILARGA ROZILIK BILDIRAMAN:

1. Men maktab sog'liqni saqlash markazi (SBHC) hamshirasi/sog'liqni saqlash provayderi farzandimga buyurgan dorilarni qabul qilishiga va SBHC hamshirasi/o'qitilgan xodimlar/sog'liqni saqlash provayderi farzandimning qonidagi qand miqdorini tekshirib ko'rishiga va ularning qondagi qandning past darajasini farzandimga tibbiy yordam ko'rsatuvchi provayder tomonidan belgilangan ko'rsatmalar va malaka darajasiga muvofiq davolashiga rozilik beraman. Ushbu tadbirlar maktab hududida yoki maktab ekskursiyalari paytida amalga oshirilishi mumkin.
2. Shuningdek, men farzandimning dorilari uchun zarur bo'lgan har qanday jihozlarni maktabda saqlash va ishlatilishiga roziman.
3. Men shuni tushunamanki:
   - Men maktab hamshirasini/sog'liqni saqlash provayderini farzandimning dorilari, sneklari, jihozlari va vositalari bilan ta'minlashim kerak va kerak bo'lganda bunday dorilar, sneklar, jihozlar va vositalarni almashtirishim kerak. Maktab salomatligi boshqarmasi (OSH) farzandimning qonida qandni tekshirish va insulinni qo'llash uchun xavfsizlik lansetlari va boshqa igna asboblari va jihozlaridan foydalanishni tavsiya qiladi.
   - Men farzandimga 504-sonli yig'ilishda aytib o'tilganidek, maktabda va sayohatlar paytida dorilarni / jihozlarini olib yurish va saqlashga ruxsat berishga roziman.
   - Maktabda beriladigan barcha retsept va retseptsiz dorilar yangi, ochilmagan va asl qadog'ida bo'lishi kerak. Farzandim maktab kunlarida foydalanishi uchun maktabni joriy, muddati o'tmagan dorilar bilan ta'minlayman.
     - Retsept bo'yicha dori qadog'i yoki flakoni dorixonaning asl yorlig'iga ega bo'lishi kerak. Yorliqda quyidagilar ko'rsatilishi kerak: **1)** farzandimning ismi, **2)** farmatsevtning ismi va telefon raqami, **3)** farzandimning sog'liqni saqlash provayderi, **4)** sana, **5)** qayta to'ldirish soni, **6)** dori nomi, **7)** dozasi, **8)** dorining maqsadi, **9)** dorini qabul qilish usuli **10)** va boshqa ko'rsatmalar.
   - Farzandimning dorilari yoki sog'liqni saqlash provayderi ko'rsatmalaridagi har qanday o'zgarishlar haqida maktab hamshirasini/sog'liqni saqlash provayderini **darhol** xabardor qilishim kerak.
   - SBHC va uning farzandimga yuqoridagi tibbiy xizmatlarni ko'rsatishda ishtirok etgan xodimlari ushbu shakldagi ma'lumotlarning to'g'riligiga tayanadi.
   - Ushbu dorilarni qabul qilish uchun ruxsatnoma shaklini (MAF) imzolash orqali men SBHCga farzandimga diabet bilan bog'liq tibbiy xizmatlar ko'rsatishga ruxsat beraman. Ushbu xizmatlar SBHCda sog'liqni saqlash provayderi yoki hamshira tomonidan klinik baholash yoki fizik tekshiruvni o'z ichiga olishi mumkin, lekin ular bilan cheklanmaydi.
   - Ushbu MAF bo'yicha dorilarga ko'rsatma berish muddati farzandimning o'quv yilining oxirida tugaydi, yozgi sessiyani o'z ichiga olishi mumkin yoki men maktab hamshirasi/SBHC provayderiga yangi MAF ni berganimda tugaydi, bu qaysi holat birinchi bo'lishiga bog'liq. Ushbu dori ko'rsatmasining amal qilish muddati tugagach, men maktab hamshirasiga/SBHC provayderiga farzandimning shifokori tomonidan yozilgan yangi ruxsatnomani beraman.
   - Maktab va Ta'lim Departamenti (DOE) farzandim qonidagi qand miqdorini xavfsiz tekshirilishiga ishonch hosil qiladi.
   - Ushbu shakl mening roziligim va ushbu shaklda tasvirlangan qandli diabetni davolash xizmatlarini olishga bo'lgan so'rovimni tashkil etadi va uni to'g'ridan-to'g'ri maktabga topshirish mumkin. Bu OSH tomonidan so'ralgan xizmatlarga rozilik hisoblanmaydi. Agar OSH ushbu xizmatlarni taqdim etishga rozi bo'lsa, farzandim yashash rejasiga muhtoj bo'lishi mumkin. Ushbu reja maktab tomonidan tuziladi.
   - Farzandimga g'amxo'rlik yoki davolanishni ta'minlash uchun OSH farzandimning sog'lig'i, dorilari yoki davolanishi haqida zarur deb hisoblagan boshqa ma'lumotlarni olishi mumkin. OSH bu ma'lumotni farzandimga tibbiy yordam ko'rsatgan har qanday provayder, hamshira yoki farmatsevtdan olishi mumkin.

ESLATMA: Farzandingiz uchun dorilar va jihozlarni maktab sayohati kuni va darsdan tashqari mashg'ulotlar uchun yuborish tavsiya etiladi.

Qandli diabetga qarshi dori vositalarni qabul qilish shakli (DMAF) uchun OSH ning ota-onalar uchun ishonch telefoni raqami: 718-786-4933

DORILAR VA/YOKI MUOLAJALARNI MUSTAQIL QABUL QILISH UCHUN (FAQAT MUSTAQIL O'QUVCHILAR):

- Farzandim barcha tayyorgarlikdan o'tganini va mustaqil ravishda dorilarni qabul qilish va/yoki muolajalarni bajara olishini tasdiqlayman. Men farzandimning maktabda va sayohat paytida ushbu shaklda ko'rsatilgan dorilarni olib yurishiga, saqlashiga va mustaqil foydalanishiga rozilik beraman. Men yuqorida aytib o'tilganidek, ushbu dorilarni farzandimga flakon yoki qutilarda yuborish uchun javobgarman. Shuningdek, men farzandimning dori vositalaridan foydalanishini nazorat qilish va farzandimning maktabda ushbu dori vositasidan foydalanishining barcha natijalari uchun javobgarman. Maktab hamshirasi yoki SBHC tibbiy yordam ko'rsatuvchi provayderlari mening farzandim dorilarni olib yurishi va mustaqil qabul qilishi mumkinligini tasdiqlaydi. Shuningdek, men maktabga tushunarli yorliqli qutilar yoki shishalarda qo'shimcha dorilarni taqdim etishga ruxsat berishga roziman.
- Agar farzandim dorilarni vaqtincha olib yura olmasa va qabul qila olmasa, men maktab hamshirasi yoki tayyorgarlikdan o'tgan maktab xodimlariga shifokor ko'rsatmasiga binoan farzandimga glyukagon berishiga roziman.

OTA-ONA/VASIY IMZOSI QUYIDA

Ota-ona/Vasiyning ismi bosma harflarda:_____ **Ota-ona/Vasiyning imzosi A & B qismlar uchun:** _____ Sana: _____

Ota-ona/Vasiy manzili: _____ Ota-ona/Vasiy elektron pochta manzili: _____

Shoshilinch bog'lanish uchun raqamlar Eng yaqin kontaktning Tel No.: _____ Uy Tel No.: _____ Uyali Tel No.: _____

Muqobil shoshilinch kontaktning ismi: _____ O'quvchiga qarindoshlik darajasi:_____ Kontakt Tel No.: _____

For Office of School Health (OSH) Use Only

OSIS Number:

Received by: Name Date:_____/_____/_____

Reviewed by: Name Date:_____/_____/_____

☐504 ☐IEP ☐Other Referred to School 504 Coordinator ☐ Yes ☐ No

Services provided by: ☐Nurse/NP ☐OSH Public Health Advisor (for supervised students only)

☐School Based Health Center

Signature and Title (RN OR SMD):

Date School Notified & Form Sent to DOE Liaison_____/_____/_____

Revisions as per OSH contact with prescribing health care practitioner

☐ **Clarified** ☐ **Modified**

Notes