NYC Health Department | Public Schools

استمارة إعطاء دواء مرض السكري

ملحق عام لإستمارة إعطاء دواء السكري (DMAF) | العام الدراسي 2026-2027

نرجو إرسال جميع استمارات إعطاء دواء مرض السكري (DMAF) بالفاكس على الرقم 8932- 396-347، أو 8945-396-347، أو عبر البريد الإلكتروني التالي OSHDMAF@health.nyc.gov .

الاستمارات المقدمة بعد يوم 1 يونيو/ حزيران قد تؤخر المعالجة للعام الدراسي الجديد

الاسم الأخير للتلميذ(ة)	الاسم الأول	تاريخ الميلاد	الجنس ☐ ذكر ☐ أنثى	رقم التعريف المدرسي (OSIS)
رقم المدرسة (ATSDBN)، أو إسمها	العنوان	الحي	المنطقة التعليمية	الصف/ الفصل

Please see 'Provider Guidelines for DMAF Completion' .This is an optional form for small changes to a diabetes regimen during the school year .for more details

:Change Student Skill Level

:Glucose Monitoring	**:Insulin Dosing & Administration**		*** I attest that the independent student** demonstrated ability to self-carry & self-administer the prescribed medication (excluding glucagon) effectively during .school, field trips, and school sponsored events
Nurse-Dependent ☐	☐ Nurse-Dependent	_____ (Provider Initials)	
☐ Supervised	☐ Supervised		
☐ Independent	☐ Independent*		

: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

*.*If starting a CGM for the first time, please submit an updated DMAF*

:Change Insulin Dosing

Discontinue all rapid-acting insulin in school, including instructions to give correction doses PRN or in the setting of ketosis ☐

: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

mg/dl from _____ AM/PM to _____ AM/PM ____ :1

mg/dl from _____ AM/PM to _____ AM/PM ____ :1

:Change insulin to carbohydrate ratio (I:C) to

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 ____ :1

:Change long-acting insulin at school :Name _____ :Dose ____ Time _____ :units pre-lunch ***OR***

Other Orders

.By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s)			
Date	**Signature**	First Name	**Health Care Provider** Last Name (PLEASE PRINT)
		MD ☐ DO ☐ NP ☐ PA ☐ **:Credentials**	
Email	ZIP	City/State	**Address** Street
CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with .diabetes	Fax	Tel	**NYS License # or NPI # (Required)**