NYC Health Department | Public Schools

糖尿病药物施用表
一般糖尿病药物施用附表

请把所有的糖尿病药物施用表（DMAF）传真到 347-396-8932/8945，或发电邮至 OSHDMAF@health.nyc.gov

学生 姓氏	名字	出生日期	性别 ☐ 男 ☐ 女	OSIS 号码
学校 ATSDBN/名称	地址	行政区	学区	年级/班级

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

Change Student Skill Level:

Glucose Monitoring:	**Insulin Dosing & Administration:**		
☐ Nurse-Dependent ☐ Supervised ☐ Independent	☐ Nurse-Dependent ☐ Supervised ☐ Independent*	_____ (Provider Initials)	*** 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.

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:

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 Last Name (PLEASE PRINT) First name **Credentials:** ☐ MD ☐ DO ☐ NP ☐ PA	**Signature**		**Date**
Address Street	City/State	ZIP	**Email**
NYS License # or NPI # (Required)	Tel	Fax	CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.