

Фамилия ребенка	Имя	Дата рождения	Пол <input type="checkbox"/> М <input type="checkbox"/> Ж	Номер учащегося (OSIS)
Школа ATSDBN / Название:	Адрес	Район	Шк. округ	Учебный уровень/класс

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: <input type="checkbox"/> Nurse-Dependent <input type="checkbox"/> Supervised <input type="checkbox"/> Independent	Insulin Dosing & Administration: <input type="checkbox"/> Nurse-Dependent <input type="checkbox"/> Supervised <input type="checkbox"/> 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.
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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)	Имя	Signature	Date
Credentials: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA			
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.