

Прізвище учня	Ім'я	Дата народження	Стать <input type="checkbox"/> Ч <input type="checkbox"/> Ж	№ OSIS
Номер школи в ATSDBN	Адреса	Район	Округ	Клас/академічний рівень

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)	First name	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.