NYC Health Department | Public Schools

Diabetga qarshi dorilarni qabul qilish shakli

Umumiy DMAF ilovasi | 2026-26-o‘quv yili

Shakllarni 347-396-8932/8945 raqamiga faks orqali yoki OSHDMAF@health.nyc.gov manziliga yuboring.

O‘quvchining familiyasi	Ism	Tug‘ilgan sanasi	Jinsi ☐ E ☐ A	OSIS #
Maktab ATSDBN raqami / nomi	Manzil	Tuman	Tuman	Sinf / dars

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	**Signature**	**Date**

Credentials: ☐ MD ☐ DO ☐ NP ☐ 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.