NYC Health Department | Public Schools

糖尿病药物施用表

保健提供者嘱咐的药物用法表 | **2026-27** 学年

6 月 1 日之后递交的表格可能会对新学年的申请程序造成延误。

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

药物用法将在提交和批准之后予以实施。如果您希望在 2026 年 9 月开始实施药物用法，请在这里打勾 ☐

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

HEALTH CARE PROVIDER COMPLETES BELOW *[Please see 'Provider Guidelines for DMAF Completion']*

SECTION A: Diagnosis

A1. Diagnosis
Diabetes Mellitus ☐ Type 1 or ☐ Type 2 or ☐ Other: _____ Dx Date _____ / _____ / _____

A2. Recent A1c
Date _____ / _____ / _____ Result _____ . _____ %

SECTION B: Emergency Orders

B1. Severe Hypoglycemia
ADMINISTER GLUCAGON AND CALL 911

Glucagon	GVOKE	Baqsimi	Zegalogue
☐ 1mg SC/IM ☐ 0.5mg SC/IM	☐ 1mg SC ☐ 0.5mg SC	☐ 3mg Intranasal	☐ 0.6mg SC Repeat in 15 min PRN

Give PRN: unconscious, unresponsive, seizure, or inability to swallow EVEN IF bG is unknown. Turn onto left side to prevent aspiration and call 911. If more than one option is chosen, school staff will use ONE form of available glucagon unless otherwise directed.

B2. Risk for Diabetic Ketoacidosis (DKA)
CALL 911 IF POSITIVE KETONES AND VOMITING, UNABLE TO TAKE PO, ALTERED MENTAL STATUS, OR BREATHING CHANGES

Test ketones if any of the following:
- vomiting
- fever ≥ 100.5 F
- bG > _____ mg/dl for the ☐ FIRST ***OR*** ☐ SECOND time that day, ≥ 2 hrs apart

If ketones small or trace, give water, re-test ketones & bG in 2 or ____ hrs

If ketones moderate or large, give water, **call parent and endocrinologist/provider and:**
☐ Give insulin correction dose if ≥ 2 hrs or ____ hrs since last rapid-acting insulin (See F6)
☐ NO GYM OR PHYSICAL ACTIVITY

SECTION C: Skill Level (*If incomplete or attestation not initialed, default is nurse dependent*)

C1. Glucose Monitoring PICK ONE	C2. Insulin Calculation & Administration PICK ONE	Skill Level: Skills include finger sticks, glucometer and/or CGM use, insulin dose calculation, and insulin administration* **Only nurses or supervised/independent students may administer insulin*
☐	☐	**Nurse-Dependent:** Nurse or trained staff must perform
☐	☐	**Supervised:** Student to perform with adult supervision
☐	☐	**Independent:** Student carries supplies & self-administers

_____
Provider Initials

FOR INDEPENDENT MEDICATION 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.

SECTION D: Glucose Monitoring

D1. Glucose Monitoring Times

Monitor PRN and:
- ☐ Breakfast
- ☐ Lunch
- ☐ Snack
- ☐ Gym
- ☐ Dismissal

☐ No bG monitoring

D2. Continuous Glucose Monitor Use
(Must complete Section G)

☐ Use CGM readings for glucose monitoring
☐ Use CGM readings for insulin dosing

For CGMs to be used for glucose monitoring and/or insulin dosing, devices must be FDA approved for use and age and used within the limits of the manufacturer's protocol.

SECTION E: Glucose Monitoring Parameters

E1. Hypoglycemia (*Provide additional hypoglycemia instructions in Section I: Other Orders*)

E1a. Oral Hypoglycemia Treatment
☐ For bG < 70 mg/dl or < _____ mg/dl, give 15 g or ____ g rapid carbs PRN. Recheck bG in 15 min or ____ min until bG > 70 mg/dl or _____ mg/dl.
☐ For bG < _____ mg/dl, give ____ g rapid carbs PRN. Recheck bG in 15 min or ____ min until bG > 70 mg/dl or _____ mg/dl.

E1b. Pre-Gym/Physical Activity Hypoglycemia Orders
☐ For bG < _____ mg/dl, no gym or physical activity
☐ For bG < _____ mg/dl, treat hypoglycemia then give uncovered snack*
☐ For bG < _____ mg/dl, give uncovered snack*

E1c. Pre-Dismissal Hypoglycemia Orders
☐ For bG < _____ mg/dl, treat hypoglycemia PRN, and give uncovered snack* before dismissed
☐ For bG < _____ mg/dl, treat hypoglycemia PRN, call parent to pick up

15 g rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz juice

*Snacks provided by staff will be between 15-25 g carbs unless otherwise specified in Section I: Other Orders

E2. Hyperglycemia
☐ For bG > _____ mg/dl pre-gym, ☐ no gym and ☐ check ketones (no gym applies regardless of ketones, for ketone parameters, see Section B2)
☐ For bG > _____ mg/dl PRN, give insulin correction if ≥ 2 hrs or ____ hrs since last rapid-acting insulin

bG "HI" reading = 500 mg/dl or _____ mg/dl

SECTION F: Insulin Orders

F1. Insulin Name

_____ ☐ No insulin in school
** May substitute Novolog with Admelog/Humalog*

F2. Insulin Delivery Method
☐ Syringe/Pen ☐ SmartPen- use app recommendations
☐ Pump (Brand) **If left blank, will use syringe/pen*

_____
**For iLet, must complete iLet Pump Orders Form*

F3. Insulin Pump Orders
**Nurse will follow pump recommendations by default*
☐ Student on FDA approved hybrid closed loop pump – basal rate variable per pump
☐ Suspend/disconnect pump for hypoglycemia not responding to treatment for _____ min
☐ Suspend/disconnect pump for gym
☐ Activity Mode: Start 60 min or ____ min prior to exercise until 120 min or ____ min after exercise

F4. Concern for Pump Failure/Pump Dislodgment
☐ For bG > _____ mg/dl that has not decreased in 2 hrs or ____ hrs after correction, consider pump failure and notify parents
☐ For suspected pump failure, SUSPEND pump and give rapid-acting insulin by syringe/pen
☐ For pump failure, only give correction dose if ≥ 2 hrs or ____ hrs since last rapid-acting insulin (See F6)
☐ In the setting of pump failure, do not use the pump to calculate insulin correction doses

F5. Insulin Calculation Methods

F5a. Carb Coverage Using: ☐ I:C ☐ Sliding Scale ☐ Fixed Dose

F5b. Correction Dose Using: ☐ ISF ☐ Sliding Scale

F5c. Insulin Dosing for Meals:

	Meal		
Insulin Dose	Breakfast	Lunch	Snack
Carb Coverage	☐	☐	☐
Correction Dose	☐	☐	☐

When carb coverage and correction doses are given at the same time, correction dose will be added when bG > target ***and*** ≥ 2 hrs or ____ hrs since last rapid-acting insulin unless otherwise specified

F5d. Exceptions to Pre-Meal Insulin Administration
☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack
☐ If bG > target bG or _____ mg/dl, give correction dose pre-meal and carb coverage after meal

Carb Coverage using I:C

$\frac{\text{\# g carb in meal}}{\text{I:C}}$ = X units insulin

Correction using ISF

$\frac{\text{bG – target bG}}{\text{ISF}}$ = Y units insulin

Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have ½ unit marks unless otherwise instructed by PCP/Endocrinologist. **Round DOWN** to nearest 0.1 unit for pumps unless following pump recommendations or PCP/Endocrinologist orders.

F6. Insulin Dose Calculation Ratios
Times will be 7am – 4pm if not specified

F6a. Target bG
_____ mg/dl from time _____ to _____
_____ mg/dl from time _____ to _____

F6b. Insulin Sensitivity Factor (ISF)
1 unit decreases bG by:
_____ mg/dl from time _____ to _____
_____ mg/dl from time _____ to _____

F6c. Insulin:Carb Ratio (I:C)
Time _____ to _____ ***OR*** Breakfast
1 unit per ____ g carbs
Time _____ to _____ ***OR*** Lunch
1 unit per _____ g carbs
Time _____ to _____ ***OR*** Snack
1 unit per ____ g carbs
☐ If gym/recess is immediately following meal, subtract ____ g carbs from meal carb calculation

学生 姓氏	名字	出生日期	OSIS 号码

SECTION F: Insulin Orders (Continued)

F7. Sliding Scales (*Provide additional sliding scales in Section I: Other Orders*)

Do **NOT** overlap ranges (e.g., 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. Provide a range from 0 to "high" bG, which is 500 mg/dl unless otherwise specified in Section E2: Hyperglycemia. Use pre-treatment bG to calculate insulin dose unless specified in Section I: Other Orders. **If no correction dose ratios or correction dose sliding scale is given, the student will not receive rapid-acting insulin outside of the specified meals and all orders for rapid-acting insulin PRN will not be implemented.**

F7a. Correction Dose

bG (mg/dl)	Units
Zero -	0
-	
-	
-	
-	
-	
-	

F7b. Carb Coverage *PLUS* Correction Dose

bG (mg/dl)	Units	Use For:
Zero -		☐ Breakfast
-		☐ Lunch
-		☐ Snack
-		☐ See attached
-		
-		
-		

F8. Fixed Dosing for Carb Coverage
Correct bG using method in Section F5a: Correction Dose and for carb coverage ADD:
☐ ____ units for breakfast (hold dose if no carbs consumed for meal)
☐ ____ units for lunch (hold dose if no carbs consumed for meal)
☐ ____ units for snack (hold dose if no carbs consumed for meal)

F9. Alternate Rounding Instructions
☐ Round insulin dosing to nearest whole unit: 0.50-1.49u rounds to 1u
☐ For half unit pen/syringe, round insulin dosing to nearest half unit: 0.25-0.74u rounds to 0.5u

F10. Long-Acting Insulin
☐ Give long-acting insulin at school
Name: _____
Dose: ____ units
Time: _____ ***OR*** pre-lunch
Long-acting insulin may be given at the same time as rapid-acting insulin at a different injection site (e.g., different arms)

SECTION G: Continuous Glucose Monitoring (CGM) Orders *[Please see 'Provider Guidelines for DMAF Completion']*

G1. Name and Model of CGM: _____

For CGMs to be used for glucose monitoring and/or insulin dosing, devices must be FDA approved for use and age and used within the limits of the manufacturer's protocol and in accordance with manufacturer's instructions. For CGM used for insulin dosing, finger stick bG will be done when symptoms don't match the CGM readings or if there is some reason to doubt the sensor (i.e. for readings < 70 mg/dl or sensor does not show both arrows and numbers). For sG < 70mg/dl, check bG and follow hypoglycemia orders on DMAF, unless otherwise ordered below.

G2. CGM Instructions: Use CGM grid below ***OR*** ☐ see attached CGM instructions.

CGM Reading	**Arrows**	**Action** ☐ **use < 80 mg/dl instead of < 70 mg/dl for grid action plan**
sG < 60 mg/dl	Any arrows	Treat hypoglycemia per bG hypoglycemia plan. Recheck in 15-20 min. If sG still < 70 mg/dl, check bG.
sG 60-69 mg/dl	↓, ↓ ↓, ↘ or →	Treat hypoglycemia per bG hypoglycemia plan. Recheck in 15-20 min. If sG still < 70 mg/dl, check bG.
sG 60-69 mg/dl	↑, ↑ ↑, or ↗	Treat hypoglycemia per bG hypoglycemia plan if symptomatic. Otherwise, recheck in 15-20 min.
sG ≥ 70 mg/dl	Any arrows	Follow bG DMAF orders for insulin dosing.
sG ≤ 120 mg/dl pre-gym or recess	↓, ↓ ↓	Give 15 g uncovered carbs. If gym or recess is immediately after lunch, subtract 15 g of carbs from lunch carb calculation.
sG ≥ 250 mg/dl	Any arrows	Follow bG DMAF orders for treatment and insulin dosing.
☐ For student using CGM, wait 2 hours after a meal before testing for ketones with hyperglycemia		

SECTION H: Parental Input into Dosing

Parent(s)/Guardian(s) (**MUST GIVE NAME**), _____, may provide the nurse with information relevant to insulin dosing, including dosing recommendations. Taking the parent's input into account, the nurse will determine the insulin dose within the range ordered by the health care provider and in keeping with nursing judgement.

SELECT ONE

☐ Nurse may adjust calculated dose up or down up to ____ units based on parental input and nursing judgement.

☐ Nurse may adjust calculated dose up by ____ % or down by ____ % of the prescribed dose based on parental input and nursing judgement.

MUST COMPLETE: Health care provider can be reached for urgent dosing orders at (_____) _____- _____. If the parent requests a similar adjustment for > 5 days in a row, the nurse will contact the health care provider to see if the school orders need to be revised.

SECTION I: Other Orders	**SECTION J: Home Medications**				
	Medication	Dose	Route	Frequency	Time

SECTION K: Additional Information

Is the child using altered or non-FDA approved equipment? ☐ **Yes** ☐ **No** [*Please note that New York State Education laws prohibit nurses from managing non-FDA approved devices. For nurse to administer insulin at school, you must provide pump failure and/or back up orders on DMAF page 1.*]

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.

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糖尿病药物施用表

家长同意表 | 2026-27 学年

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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

各位家长和监护人：通读、填写并签名。我在下面签名，表示我同意如下：

1. 我同意，根据我子女保健服务提供者的说明和所确定的技能水平，护士/学校健康中心（SBHC）服务提供者可以为我的子女施用我子女的处方药物，且护士/经训练的教职工/SBHC 服务提供者可以检查我子女的血糖，并处理我子女的低血糖问题。这些措施可以在学校场地或在学校组织的外出活动途中进行。
2. 我也同意，我子女的医药所需的任何器材都在学校里储存和使用。
3. 我理解：
   - 我必须将我子女的医药品、零食、器材及有关用品交给学校护士/SBHC 服务提供者，并必须按需要补充这些医药品、零食、器材及有关用品。学校健康办公室（OSH）建议使用安全采血针和其他安全针具及相应用品检查我子女的血糖水平和补给胰岛素。
   - 我同意按照子女 504 会议所述，让子女在学校和学校外出活动时携带并储存其使用的药品/有关用品。
   - 我给予学校的所有处方和非处方药物都必须是新的、未曾开封过并装在其原封瓶子或盒子里。我将给学校提供我子女在上学日所需的当前、未过期的医药用品。
     - 处方药物必须在其盒子或瓶子上有原装药房标签。标签必须包括：**1)** 我子女的姓名；**2)** 药房名称和电话号码；**3)** 我子女的保健服务提供者姓名；**4)** 日期；**5)** 重配次数；**6)** 药物名称；**7)** 剂量；**8)** 何时用药；**9)** 如何用药；**10)** 任何其他说明。
   - 如果我子女的药物或者保健服务提供者的说明有任何变化，我必须**立即**告知学校护士/SBHC 提供者。
   - 参与为我子女提供上述健康服务的学校健康办公室（OSH）及其代理人员依赖于本表格信息的精确度。
   - 我在这份“药物施用表”（MAF）上签名，表示授权学校健康办公室（OSH）为我子女提供糖尿病相关的健康服务。这些服务可以包括（但不限于）由一名 OSH 办公室保健服务提供者或护士所执行的临床评估或体检。
   - 这份 MAF 表所嘱咐的药物用法在以下时间失效：我子女的学年结束时（这可能包括暑期班），或者在我交给学校护士/SBHC 服务提供者一份新的 MAF 时（以时间较早者为准）。当这份嘱咐的药物用法表失效时，我将交给子女的学校护士/SBHC 服务提供者一份新的由我子女的保健服务提供者出具的 MAF。
   - 学校健康办公室（OSH）和教育局（DOE）负责确保我的子女能够安全地测试自己的血糖。
   - 这份表格代表我同意并要求提供本表格内说明的糖尿病服务，并可以直接发送给学校健康办公室（OSH）。这并非 OSH 提供所要求的服务的协议。如果 OSH 决定提供这些服务，我子女可能还需要一份“学生特别照顾计划”（Student Accommodation Plan）。这份计划将由学校填写。
   - 为着给我子女提供护理或治疗的目的，OSH 可以获取该办公室认为所需要的有关我子女的健康问题、药物和治疗相关的任何其他信息。OSH 可以向任何为我子女提供健康服务的保健服务提供者、护士或药剂师索取该信息。

请注意：最好是您在学校外出活动的日子和在校外进行学校活动时给子女带上药物和器材。

查询有关糖尿病药物施用表（DMAF）的 OSH 家长热线：718-786-4933

自己用药和/或进行医疗程序（仅适用于能自己独立用药的学生）：

- 我证明/确认，我子女已得到完全的训练并能够自行用药和/或进行医疗程序。我同意，我的子女在学校里以及在学校外出活动时自己携带、储存并施用本表格上所开具的药物。我负责根据上述说明把瓶子或盒子里的药物交给我子女。我也负责监督我子女在学校里的药物使用情况及其对这一药物使用所导致的任何后果。学校护士或 SBHC 服务提供者将确认我子女拥有携带和自行用药的能力。我也同意交给学校“备用”药物（装在清楚地标示的盒子或瓶子里）。
- 如果我的子女暂时无法携带药品和用药，我同意学校护士或受过训练的学校员工按照保健服务提供者所开具的处方给我的子女施用胰高血糖素。

家长/监护人在下方签名		
清楚书写家长/监护人的姓名	**针对 A 和 B 部分的家长/监护人签名**	**签名日期**

家长/监护人地址		家长/监护人电子邮箱	
紧急联络号码	最佳联络电话号码	住家电话号码：	手机号码
其他紧急联络人姓名		与学生的关系	联络电话号码

For Office of School Health (OSH) Use Only（仅供工作人员填写）

OSIS Number:	
Received by: Name	**Date:** ____ / ____ / _____
Reviewed by: Name	**Date:** ____ / ____ / _____
☐ 504 ☐ IEP ☐ Other	**Referred to School 504 Coordinator:** ☐ Yes ☐ No
Services provided by:	☐ Nurse/NP ☐ School Based Health Center ☐ OSH Public Health Advisor (for supervised students only)
Signature and Title (RN or SMD):	**Date:** ____ / ____ / _____
Date School Notified & Form Sent to DOE Liaison: ____ / ____ / _____	
Revisions as per OSH contact with prescribing health care practitioner: ☐ Clarified ☐ Modified	
Notes:	