

6月1日之後遞交的表格可能會對新學年的申請程序造成延誤。

請把所有的糖尿病藥物施用表 (DMAF) 傳真到 347-396-8932/8945, 或發電郵至 OSHDMAF@health.nyc.gov

藥物用法將在提交和批准之後予以實施。如果您希望在 2026 年 9 月開始實施藥物用法, 請在這裏打勾

學生 姓氏 _____ 名字 _____	出生日期 _____	性別 <input type="checkbox"/> 男 <input type="checkbox"/> 女	OSIS 號碼 _____
學校 ATSDBN/名稱 _____	地址 _____	行政區 _____	學區 _____ 年級/班級 _____

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

SECTION A: Diagnosis

A1. Diagnosis Diabetes Mellitus <input type="checkbox"/> Type 1 or <input type="checkbox"/> Type 2 or <input type="checkbox"/> Other: _____ Dx Date ____/____/____	A2. Recent A1c Date ____/____/____ Result ____ . ____ %
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SECTION B: Emergency Orders

<p style="text-align: center;">B1. Severe Hypoglycemia ADMINISTER GLUCAGON AND CALL 911</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Glucagon <input type="checkbox"/> 1mg SC/IM <input type="checkbox"/> 0.5mg SC/IM</td> <td style="width:25%;">GVOKE <input type="checkbox"/> 1mg SC <input type="checkbox"/> 0.5mg SC</td> <td style="width:25%;">Baqsimi <input type="checkbox"/> 3mg Intranasal</td> <td style="width:25%;">Zegalogue <input type="checkbox"/> 0.6mg SC Repeat in 15 min PRN</td> </tr> </table> <p>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.</p>	Glucagon <input type="checkbox"/> 1mg SC/IM <input type="checkbox"/> 0.5mg SC/IM	GVOKE <input type="checkbox"/> 1mg SC <input type="checkbox"/> 0.5mg SC	Baqsimi <input type="checkbox"/> 3mg Intranasal	Zegalogue <input type="checkbox"/> 0.6mg SC Repeat in 15 min PRN	<p style="text-align: center;">B2. Risk for Diabetic Ketoacidosis (DKA) CALL 911 IF POSITIVE KETONES AND VOMITING, UNABLE TO TAKE PO, ALTERED MENTAL STATUS, OR BREATHING CHANGES</p> <p>Test ketones if any of the following: • vomiting • fever ≥ 100.5 F • bG > _____ mg/dl for the <input type="checkbox"/> FIRST OR <input type="checkbox"/> SECOND time that day, ≥ 2 hrs apart</p> <p>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: <input type="checkbox"/> Give insulin correction dose if ≥ 2 hrs or _____ hrs since last rapid-acting insulin (See F6) <input type="checkbox"/> NO GYM OR PHYSICAL ACTIVITY</p>
Glucagon <input type="checkbox"/> 1mg SC/IM <input type="checkbox"/> 0.5mg SC/IM	GVOKE <input type="checkbox"/> 1mg SC <input type="checkbox"/> 0.5mg SC	Baqsimi <input type="checkbox"/> 3mg Intranasal	Zegalogue <input type="checkbox"/> 0.6mg SC Repeat in 15 min PRN		

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

C1. Glucose Monitoring <u>PICK ONE</u>	C2. Insulin Calculation & Administration <u>PICK ONE</u>	<p>Skill Level: Skills include finger sticks, glucometer and/or CGM use, insulin dose calculation, and insulin administration* <i>*Only nurses or supervised/independent students may administer insulin</i></p> <p><input type="checkbox"/> Nurse-Dependent: Nurse or trained staff must perform</p> <p><input type="checkbox"/> Supervised: Student to perform with adult supervision</p> <p><input type="checkbox"/> Independent: Student carries supplies & self-administers</p> <p>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.</p>	SECTION D: Glucose Monitoring
<input type="checkbox"/>	<input type="checkbox"/>		<p>D1. Glucose Monitoring Times</p> <p>Monitor PRN and: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Gym <input type="checkbox"/> Dismissal <input type="checkbox"/> No bG monitoring</p>
Provider Initials _____			<p>D2. Continuous Glucose Monitor Use <i>(Must complete Section G)</i></p> <p><input type="checkbox"/> Use CGM readings for glucose monitoring <input type="checkbox"/> Use CGM readings for insulin dosing</p> <p>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.</p>

SECTION E: Glucose Monitoring Parameters

<p>E1. Hypoglycemia (Provide additional hypoglycemia instructions in Section I: Other Orders)</p> <p>E1a. Oral Hypoglycemia Treatment <input type="checkbox"/> 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. <input type="checkbox"/> For bG < _____ mg/dl, give _____ g rapid carbs PRN. Recheck bG in 15 min or _____ min until bG > 70 mg/dl or _____ mg/dl.</p> <p>E1b. Pre-Gym/Physical Activity Hypoglycemia Orders <input type="checkbox"/> For bG < _____ mg/dl, no gym or physical activity <input type="checkbox"/> For bG < _____ mg/dl, treat hypoglycemia then give uncovered snack* <input type="checkbox"/> For bG < _____ mg/dl, give uncovered snack*</p> <p>E1c. Pre-Dismissal Hypoglycemia Orders <input type="checkbox"/> For bG < _____ mg/dl, treat hypoglycemia PRN, and give uncovered snack* before dismissed <input type="checkbox"/> For bG < _____ mg/dl, treat hypoglycemia PRN, call parent to pick up</p>	<p>15 g rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz juice</p> <p>*Snacks provided by staff will be between 15-25 g carbs unless otherwise specified in Section I: Other Orders</p>
<p>E2. Hyperglycemia <input type="checkbox"/> For bG > _____ mg/dl pre-gym, <input type="checkbox"/> no gym and <input type="checkbox"/> check ketones (no gym applies regardless of ketones, for ketone parameters, see Section B2) <input type="checkbox"/> For bG > _____ mg/dl PRN, give insulin correction if ≥ 2 hrs or _____ hrs since last rapid-acting insulin</p>	<p>bG "HI" reading = 500 mg/dl or _____ mg/dl</p>

SECTION F: Insulin Orders

<p>F1. Insulin Name _____ <input type="checkbox"/> No insulin in school * May substitute Novolog with Admelog/Humalog</p> <p>F2. Insulin Delivery Method <input type="checkbox"/> Syringe/Pen <input type="checkbox"/> SmartPen- use app recommendations <input type="checkbox"/> Pump (Brand) *If left blank, will use syringe/pen</p> <p>*For iLet, must complete iLet Pump Orders Form</p> <p>F3. Insulin Pump Orders *Nurse will follow pump recommendations by default <input type="checkbox"/> Student on FDA approved hybrid closed loop pump - basal rate variable per pump <input type="checkbox"/> Suspend/disconnect pump for hypoglycemia not responding to treatment for _____ min <input type="checkbox"/> Suspend/disconnect pump for gym <input type="checkbox"/> Activity Mode: Start 60 min or _____ min prior to exercise until 120 min or _____ min after exercise</p> <p>F4. Concern for Pump Failure/Pump Dislodgment <input type="checkbox"/> For bG > _____ mg/dl that has not decreased in 2 hrs or _____ hrs after correction, consider pump failure and notify parents <input type="checkbox"/> For suspected pump failure, SUSPEND pump and give rapid-acting insulin by syringe/pen <input type="checkbox"/> For pump failure, only give correction dose if ≥ 2 hrs or _____ hrs since last rapid-acting insulin (See F6) <input type="checkbox"/> In the setting of pump failure, do not use the pump to calculate insulin correction doses</p>	<p>F5. Insulin Calculation Methods F5a. Carb Coverage Using: <input type="checkbox"/> I:C <input type="checkbox"/> Sliding Scale <input type="checkbox"/> Fixed Dose F5b. Correction Dose Using: <input type="checkbox"/> ISF <input type="checkbox"/> Sliding Scale F5c. Insulin Dosing for Meals:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td colspan="3" style="text-align: center;">Meal</td> </tr> <tr> <td style="text-align: center;">Insulin Dose</td> <td style="text-align: center;">Breakfast</td> <td style="text-align: center;">Lunch</td> <td style="text-align: center;">Snack</td> </tr> <tr> <td style="text-align: center;">Carb Coverage</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Correction Dose</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>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</p> <p>F5d. Exceptions to Pre-Meal Insulin Administration <input type="checkbox"/> Give insulin after: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> If bG > target bG or _____ mg/dl, give correction dose pre-meal and carb coverage after meal</p> <p>F5e. Carb Coverage using I:C # g carb in meal : I:C = X units insulin</p> <p>Correction using ISF $\frac{bG - target\ bG}{ISF} = Y\ units\ insulin$</p> <p>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.</p>		Meal			Insulin Dose	Breakfast	Lunch	Snack	Carb Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Correction Dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>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 _____</p> <p>F6b. Insulin Sensitivity Factor (ISF) 1 unit decreases bG by: _____ mg/dl from time _____ to _____ _____ mg/dl from time _____ to _____</p> <p>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</p> <p><input type="checkbox"/> If gym/recess is immediately following meal, subtract _____ g carbs from meal carb calculation</p>
	Meal																	
Insulin Dose	Breakfast	Lunch	Snack															
Carb Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
Correction Dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															

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學生 姓氏	名字	出生日期	OSIS 號碼
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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 -		<input type="checkbox"/> Breakfast
-		<input type="checkbox"/> Lunch
-		<input type="checkbox"/> Snack
-		<input type="checkbox"/> 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 <input type="checkbox"/> 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: <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.

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學生 姓氏	名字	出生日期	性別 <input type="checkbox"/> 男 <input type="checkbox"/> 女	OSIS 號碼
學校 ATSDBN/名稱	地址	行政區	學區	年級/班級

各位家長和監護人：通讀、填寫並簽名。我在下面簽名，表示我同意如下：

- 我同意，根據我子女保健服務提供者的說明和所確定的技能水平，護士/學校健康中心 (SBHC) 服務提供者可以為我的子女施用我子女的處方藥物，且護士/經訓練的教職工/SBHC 服務提供者可以檢查我子女的血糖，並處理我子女的低血糖問題。這些措施可以在學校場地或在學校組織的外出活動途中進行。
- 我也同意，我子女的醫藥所需的任何器材都在學校裏儲存和使用。
- 我理解：
 - 我必須將我子女的醫藥品、零食、器材及有關用品交給學校護士/SBHC 服務提供者，並必須按需要補充這些醫藥品、零食、器材及有關用品。學校健康辦公室 (OSH) 建議使用安全採血針和其他安全針具及相應用品檢查我子女的血糖水平和補給胰島素。
 - 我同意按照子女 504 會議所述，讓子女在學校和學校外出活動時攜帶並儲存其使用的藥品/有關用品。
 - 我給予學校的所有處方和非處方藥物都必須是新的、未曾開封過並裝在其原封瓶子或盒子裏。我將給學校提供我子女在上學日所需的當前、未過期的醫藥用品。
 - 處方藥物必須在其盒子或瓶子上有原裝藥房標籤。標籤必須包括：**1) 我子女的姓名；2) 藥房名稱和電話號碼；3) 我子女的保健服務提供者姓名；4) 日期；5) 重配次數；6) 藥物名稱；7) 劑量；8) 何時用藥；9) 如何用藥；10) 任何其他說明。**
 - 如果我子女的藥物或者保健服務提供者的說明有任何變化，我必須立即告知學校護士/SBHC 提供者。
 - 參與為我子女提供上述健康服務的學校健康辦公室 (OSH) 及其代理人員依賴於本表格資訊的精確度。
 - 我在這份「藥物施用表」(MAF) 上簽名，表示授權學校健康辦公室 (OSH) 為我子女提供糖尿病相關的健康服務。這些服務可以包括 (但不限於) 由一名 OSH 辦公室保健服務提供者或護士所執行的臨床評估或體檢。
 - 這份 MAF 表所囑咐的藥物用法在以下時間失效：我子女的學年結束時 (這可能包括暑期班)，或者在我交給學校護士/SBHC 服務提供者一份新的 MAF 時 (以時間較早者為準)。當這份囑咐的藥物用法表失效時，我將交給子女的學校護士/SBHC 服務提供者一份新的由我子女的保健服務提供者出具的 MAF。
 - 學校健康辦公室 (OSH) 和教育局 (DOE) 負責確保我的子女能夠安全地測試自己的血糖。
 - 這份表格代表我同意並要求提供本表格內說明的糖尿病服務，並可以直接發送給學校健康辦公室 (OSH)。這並非 OSH 提供所要求的服務的協議。如果 OSH 決定提供這些服務，我子女可能還需要一份「學生特別照顧計劃」(Student Accommodation Plan)。這份計劃將由學校填寫。
 - 為著給我子女提供護理或治療的目的，OSH 可以獲取該辦公室認為所需要的有關我子女的健康問題、藥物和治療相關的任何其他資訊。OSH 可以向任何為我子女提供健康服務的保健服務提供者、護士或藥劑師索取該資訊。

請注意：最好是您在學校外出活動的日子和在校外進行學校活動時給子女帶上藥物和器材。

查詢有關糖尿病藥物施用表 (DMAF) 的 OSH 家長熱線：718-786-4933

自己用藥和/或進行醫療程序 (僅適用於能自己獨立用藥的學生)：

- 我證明/確認，我子女已得到完全的訓練並能夠自行用藥和/或進行醫療程序。我同意，我的子女在學校裏以及在學校外出活動時自己攜帶、儲存並施用本表格上所開具的藥物。我負責根據上述說明把瓶子或盒子裏的藥物交給我子女。我也負責監督我子女在學校裏的藥物使用情況及其對這一藥物使用所導致的任何後果。學校護士或 SBHC 服務提供者將確認我子女擁有攜帶和自行用藥的能力。我也同意交給學校「備用」藥物 (裝在清楚地標示的盒子或瓶子裏)。
- 如果我的子女暫時無法攜帶藥品和用藥，我同意學校護士或受過訓練的學校員工按照保健服務提供者所開具的處方給我的子女施用胰高血糖素。

家長/監護人在下方簽名

清楚書寫家長/監護人的姓名	針對 A 和 B 部分的家長/監護人簽名	簽名日期
家長/監護人地址	家長/監護人電子郵箱	
緊急聯絡號碼	最佳聯絡電話號碼	住家電話號碼： 手機號碼
其他緊急聯絡人姓名	與學生的關係	聯絡電話號碼

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For Office of School Health (OSH) Use Only (僅供工作人員填寫)

OSIS Number:	
Received by: Name	Date: ____ / ____ / ____
Reviewed by: Name	Date: ____ / ____ / ____
<input type="checkbox"/> 504 <input type="checkbox"/> IEP <input type="checkbox"/> Other	Referred to School 504 Coordinator: <input type="checkbox"/> Yes <input type="checkbox"/> No
Services provided by:	<input type="checkbox"/> Nurse/NP <input type="checkbox"/> School Based Health Center <input type="checkbox"/> 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: <input type="checkbox"/> Clarified <input type="checkbox"/> Modified	
Notes:	