Fòm pou bay medikaman kont dyabèt

Fòm pou founisè preskri medikaman | Ane lekòl 2026-2027

Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la.

Tanpri fakse tout DMAF nan 347-396-8932/8945 oswa imèl OSHDMAF@health.nyc.gov

Y ap fè enplemantasyon preskripsyon alekri yo lè yo voye yo ale epi apwouve yo. Si w ta vle kòmanse enplemantasyon preskripsyon an septanm 2026, tanpri tcheke la a ☐

Student Last Name	Non elèv la	Dat nesans li	Sèks ☐ Gason ☐ Fi	# OSIS:
Non/ATSDBN **lekòl** la	Adrès	Borough	Distri	Nivo klas/salklas

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.
☐ Pou bG < _____ mg/dl, bay ____ g rapid carbs PRN. Recheck bG in 15 min or ____ min until bG > 70 mg/dl or _____ mg/dl.

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

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

*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. Inkyetid pou ponp ki pa fonksyone/ki deranje
☐ 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

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

Correction using ISF

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

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 ___ gms carbs

Lè ________ rive ________ ***Oswa*** Manje midi

1 unit per _____ g carbs

Lè ________ rive ________ ***Oswa*** Snack

1 unit per ___ gms carbs

☐ If gym/recess is immediately following meal, subtract ____ g carbs from meal carb calculation

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SECTION F: Insulin Orders (Continued)

F7. Sliding Scales (*Bay sliding scales siplemantè nan Sek 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 awondi l a 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
Lè: ________ ***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. Ekplikasyon pou CGM: 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	↓, ↓↓, ↘ oswa →	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	nenpòt flèch	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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Non/ATSDBN **lekòl** la	Adrès	Borough	Distri	Nivo klas/salklas

PARAN AK RESPONSAB: LI, RANPLI AK SIYEN. LÈ M SIYEN PI BA A, MWEN DAKÒ AVÈK BAGAY SA YO:

1. Mwen dakò pou enfimyè/founisè SBHC a bay pitit mwen an medikaman yo preskri yo, ak pou enfimyè/estaf ki fòme/founisè SBHC tcheke nivo sik nan san pitit mwen an epi pou trete nivo sik nan san pitit mwen an dapre rekòmandasyon ak nivo abilite doktè k ap pran swen pitit mwen an detèmine a. Yo ka fè bagay sa yo nan lekòl la oswa pandan pwomnad lekòl la.
2. Mwen dakò tou pou nenpòt ekipman yo bezwen pou yo ka konsève ak itilize medikaman pitit mwen an nan lekòl la.
3. Mwen konprann ke:
   - Mwen sipoze remèt enfimyè lekòl /founisè SBHC a medikaman, snacks, ekipman, ak materyèl yo epi mwen dwe ranplase medikaman, ekipman ak materyèl sa yo lè sa nesesè. Biwo sante lekòl (Office of School Health, OSH) rekòmande pou itilize lansèt sekirite ak lòt ti aparèy egui sekirite ak founiti pou tcheke nivo sik nan san pitit mwen an epi bay ensilin.
   - Mwen dakò pou pitit mwen an pote ak estoke medikaman/founiti yo nan lekòl la ak nan pwomnad jan yo te di sa nan reyinyon 504 li a.
   - Tout medikaman sou preskripsyon ak tout medikaman "ki vann san preksripsyon (over-the-counter)" fèt pou nèf, kachte nan bwat oswa boutèy orijinal la. M ap bay lekòl la medikaman ki resan, ki pa ekspire pou pitit mwen itilize pandan jounen lekòl la.
     - Medikaman ki vann sou preskripsyon yo fèt pou gen etikèt **orijinal** famasi a sou bwat la oswa sou boutèy la. Etikèt la dwe gen ladan: **1)** non pitit mwen an, **2)** non ak nimewo telefòn famasi a, **3)** non doktè pitit mwen an, **4)** dat, **5)** kantite rechaj (refill), **6)** non medikaman an, **7)** dozaj, **8)** lè pou li pran l, **9)** kòman pou li pran medikaman an ak **10)** nenpòt lòt eksplikasyon.
   - Mwen dwe **imedyatman** di enfimyè lekòl la/founisè SBHC a nenpòt chanjman ki genyen nan medikaman pitit mwen an oswa nan eksplikasyon founisè swen sante k ap trete l la.
   - OSH ak ajan li ki patisipe nan ofri pitit mwen an sèvis sante ki pi wo yo konte sou presizyon ki nan enfòmasyon ki sou fòm sa a.
   - Lè m siyen fòm pou bay medikaman sa a (medication administration form, MAF) sa a, mwen otorize OSH pou bay pitit mwen an sèvis sante. Sèvis sa yo ka genyen ladan pami lòt, yon evalyasyon klinik oswa yon konsiltasyon medikal yon founisè swen sante oswa yon enfimyè OSH fè.
   - Medikaman ki sou fòm MAF sa a ekspire nan fen ane lekòl pitit mwen an, ki ka gen ladan tou sesyon ete, oswa lè mwen bay enfimyè lekòl la / founisè SBHC a yon nouvo fòm MAF (kèlkeswa sa ki rive avan an). Lè preskripsyon medikaman sa a ekspire, m ap bay enfimyè/founisè SBHC lekòl pitit mwen an yon nouvo fòm MAF ke founisè swen sante pitit mwen an ap ekri.
   - OSH ak Depatman edikasyon (DOE) asire yo pitit mwen an ka tcheke nivo sik nan san l ansekirite.
   - Fòm sa a reprezante konsantman m ak demand mwen fè pou sèvis dyabèt yo dekri sou fòm sa a, epi mwen ka voye l dirèkteman bay OSH. Se pa yon akò OSH genyen pou li bay sèvis ou mande a. Si OSH deside bay sèvis sa yo, pitit mwen an bezwen tou yon Plan akomodasyon pou elèv. Se lekòl la k ap ranpli plan sa a.
   - Nan objektif pou bay pitit mwen an swen oswa tretman, OSH ka gen nenpòt lòt enfòmasyon yo panse ki nesesè sou pwoblèm medikal pitit mwen an, medikaman l ap pran oswa tretman l ap suiv. OSH ka pran enfòmasyon sa a nan men nenpòt founisè swen sante, enfimyè oswa famasyen ki bay pitit mwen an sèvis.

SONJE: Li pi bon si w voye medikaman ak ekipman pou pitit ou a nan jou yon pwomnad lekòl ak nan aktivite k ap fèt andeyò lokal lekòl la.

Liy gratis OSH pou paran poze kesyon sou DMAF: 718-786-4933

POU ELÈV KI KA PRAN MEDIKAMN AK/OSWA FÈ PWOSEDI YO POUKONT YO (ELÈV KI ENDEPANDAN SÈLMAN):

- Mwen sètifye/konfime pitit mwen an resevwa bonjan trening epi li kapab pran medikaman ak/oswa fè pwosedi yo poukont li. Mwen dakò pou pitit mwen an pote, konsève ak ak pou l pran medikaman yo preskri nan fòm sa a nan lekòl la ak nan pwomnad. Mwen gen responsablite pou bay pitit mwen an medikaman sa a nan boutèy oswa nan bwat yo jan yo dekri sa pi wo a. Mwen gen responsablite pou m sipèvize itilizasyon medikaman pitit mwen an, ak pou tout konsekans ki genyen nan itilizasyon medikaman pitit mwen an pran nan lekòl la. Enfimyè lekòl la oswa founisè SBHC pral konfime kapasite pitit mwen an pou l pote ak pran medikaman an limenm. Mwen dakò tou pou m bay lekòl la medikaman "an rezèv" nan yon bwat oswa boutèy ki gen etikèt byen klè sou li.
- Mwen dakò pou enfimyè lekòl la oswa manm estaf ki resevwa trening bay pitit mwen an Glucagon si se yon doktè ki preskri l si pitit mwen an pa kapab pran l poukont li pou yon ti tan.

PARAN/RESPONSAB, SIYEN PI BA A		
Ekri ak lèt detache Non paran/responsab	**Siyati paran/responsab pou Pati A & B**	**Dat siyati a**

Adrès paran/responsab		Imèl paran/responsab la	
Nimewo telefòn pou ka ijans	Pi bon nimewo telefon pou kontakte w	No. telefòn lakay ou	No. telefòn selilè
Non lòt moun pou kontakte nan ka ijans		Lyen avèk elèv la	No. telefòn Jan pou kontakte nou

For Office of School Health (OSH) Use Only

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:	