

رقم التعريف المدرسي (OSIS)	الجنس <input type="checkbox"/> ذكر <input type="checkbox"/> أنثى	تاريخ الميلاد	الاسم الأول	الاسم الأخير للتمييز (ATSDBN)، أو اسمها
الصف/الفصل	المنطقة التعليمية	الحي	العنوان	رقم المدرسة (ATSDBN)، أو اسمها

The iLet pump does not deliver correction dose .**These orders must be submitted with Pages 1 and 2 of the SY 26-27 DMAF**  
 If you would like the school nurse to use the iLet pump, you must provide carbohydrate ranges for boluses or use carb ratios  
 .“less”, “usual”, and “more” carbohydrates **or** select one option the nurse should use for each meal

GLUCOSE TARGET	
Usual (120 mg/dl) <input type="checkbox"/> Lower (110 mg/dl) <input type="checkbox"/> Higher (130 mg/dl)	

MEAL ANNOUNCEMENTS	
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**Select meal size based on carbohydrate content in**  
 You may use large ranges, e.g., 15-100 g carbs .meal

**Use selected meal size regardless of how many**  
 carbs the student is eating

Meal Size Carbohydrate Range (g)			Meal Type
More	Usual	Less*	
-	-	-	Breakfast
-	-	-	Lunch

**OR**

Meal Size			Meal Type
More	Usual	Less*	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breakfast
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lunch

*\* If the “Less” option is not available, do not announce the meal/snack*

**General iLet Insulin Pump Orders**

**Do not announce meals/snacks with carbohydrate content under 15 g or**  
 \_\_\_\_\_ g carbs

Do not announce meals/snacks more than 15 min or \_\_\_\_\_ min prior to eating

Do not announce meals/snacks if it has been more than 30 min or \_\_\_\_\_ min  
 since the student started eating

If the student eats **:ONLY IF CARBOHYDRATE RANGES GIVEN ABOVE**

more carbohydrates after a meal announcement, announce again for the

Only consider the amount of additional carbs when .additional carbs

choosing the additional meal size; do not include carbs that were already  
 .announced

**:Announce all snacks as (PICK ONE)**

Less” lunch“

“Less” breakfast

Closest meal in time

Closest meal based on usual carb content  
 (must give range of carbs above)

\_\_\_\_\_ :  Other

Do not announce snacks

ACTIVITY PARAMETERS	
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Pause pump 60 min or \_\_\_\_\_ min before starting activity and restart immediately or \_\_\_\_\_ min after activity

If lunch is immediately before activity, do not pause pump until activity starts

**After** pausing pump for activity, give \_\_\_\_\_ g of uncovered carbs pre-activity if bG < \_\_\_\_\_ mg/dl

Do not pause pump or give uncovered carbohydrates prior to activity

PUMP FAILURE ORDERS	
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= \_\_\_\_\_ mg/dl Target bG

mg/dl \_\_\_\_\_ :1 ISF

g \_\_\_\_\_ :1 I:C

In the event of iLet pump failure, contact  
 parent/endocrinologist/provider for dosing instructions or use  
 .the following ratios to deliver insulin via syringe/pen

Other Orders	
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**.By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s)**

Date	Signature	First name	Health Care Provider Last Name (PLEASE PRINT)
		MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> :Credentials	
Email		ZIP	City/State
		Address Street	

CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with .diabetes	Fax	Tel	NYS License # or NPI # (Required)
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