

Buyurtmalar topshirilgan va tasdiqlangandan keyin bajariladi. Agar siz 2026-yil sentabrda buyurtmani amalga oshirishni boshlamoqchi bo'lsangiz, bu yerni tekshiring

O'quvchining familiyasi	Ismi	Tug'ilgan sanasi	Jinsi <input type="checkbox"/> E <input type="checkbox"/> A	OSIS #
Maktab ATSDBN raqami / nomi	Manzil	Tuman	Tuman	Sinf / dars

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 initiated, default is nurse dependent)

SECTION D: Glucose Monitoring

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	D1. Glucose Monitoring Times	D2. Continuous Glucose Monitor Use (Must complete Section G)
<input type="checkbox"/>	<input type="checkbox"/>	Nurse-Dependent: Nurse or trained staff must perform	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	<input type="checkbox"/> Use CGM readings for glucose monitoring
<input type="checkbox"/>	<input type="checkbox"/>	Supervised: Student to perform with adult supervision		<input type="checkbox"/> Use CGM readings for insulin dosing
<input type="checkbox"/>	<input type="checkbox"/>	Independent: Student carries supplies & self-administers		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.
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 E: Glucose Monitoring Parameters

E1. Hypoglycemia (Provide additional hypoglycemia instructions in Section I: Other Orders) 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.	15 g rapid carbs = 4 glucose tabs = 1 glucose gel tube = 4 oz juice
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*	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
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	
bG "HI" reading = 500 mg/dl or _____ mg/dl	

SECTION F: Insulin Orders

F1. Insulin Name _____ <input type="checkbox"/> No insulin in school * May substitute Novolog with Admelog/Humalog	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: <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>		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"/>	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 <input type="checkbox"/> If gym/recess is immediately following meal, subtract _____ g carbs from meal carb calculation
	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"/>															
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 *For iLet, must complete iLet Pump Orders Form	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 <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																	
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	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	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"> Carb Coverage using I:C $\frac{\# \text{ g carb in meal}}{\text{I:C}} = X \text{ units insulin}$ </td> <td style="width:50%;"> Correction using ISF $\frac{\text{bG} - \text{target bG}}{\text{ISF}} = Y \text{ units insulin}$ </td> </tr> <tr> <td colspan="2"> 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. </td> </tr> </table>	Carb Coverage using I:C $\frac{\# \text{ g carb in meal}}{\text{I:C}} = X \text{ units insulin}$	Correction using ISF $\frac{\text{bG} - \text{target bG}}{\text{ISF}} = Y \text{ units insulin}$	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.													
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1-iyundan keyin topshirilgan shakllarni ko'rib chiqish yangi o'quv yiliga davom etishi mumkin.

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

O'quvchining familiyasi	Ismi	Tug'ilgan sanasi	OSIS #
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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.**

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)

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
-		
-		
-		
-		

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.

1-iyundan keyin topshirilgan shakllarni ko'rib chiqish yangi o'quv yilgacha davom etishi mumkin.

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

O'quvchining familiyasi	Ismi	Tug'ilgan sanasi	Jinsi <input type="checkbox"/> E <input type="checkbox"/> A	OSIS #
Maktab ATSDBN raqami / nomi	Manzil	Tuman	Tuman	Sinf / dars

OTA-ONALAR VA VASIYLAR: O'QIDIM, TO'LDIRDIM VA IMZO CHEKDIM. IMZO CHEKISH ORQALI MEN QUYIDAGILARGA ROZILIK BILDIRAMAN:

- Men maktab sog'liqni saqlash markazi (SBHC) hamshirasi/sog'liqni saqlash provayderi farzandimga buyurgan dorilarni qabul qilishiga va SBHC hamshirasi/o'qitilgan xodimlar/sog'liqni saqlash provayderi farzandimning qonidagi qand miqdorini tekshirib ko'rishiga va ularning qondagi qandning past darajasini farzandimga tibbiy yordam ko'rsatuvchi provayder tomonidan belgilangan ko'rsatmalar va malaka darajasiga muvofiq davolashga rozilik beraman. Ushbu tadbirlar maktab hududida yoki maktab ekskursiyalari paytida amalga oshirilishi mumkin.
- Shuningdek, men farzandimning dorilari uchun zarur bo'lgan har qanday jihozlarni maktabda saqlash va ishlatilishiga roziman.
- Men shuni tushunamanki:
 - Men maktab hamshirasi/sog'liqni saqlash provayderini farzandimning dorilari, sneklari, jihozlari va vositalari bilan ta'minlashim kerak va kerak bo'lganda bunday dorilar, sneklar, jihozlar va vositalarni almashtirishim kerak. Maktab salomatligi boshqarmasi (OSH) farzandimning qonida qandni tekshirish va insulinni qo'llash uchun xavfsizlik lansetlari va boshqa igna asboblari va jihozlaridan foydalanishni tavsiya qiladi.
 - Men farzandimga 504-sonli yig'ilishda aytib o'tilganidek, maktabda va sayohatlar paytida dorilarni / jihozlarini olib yurish va saqlashga ruxsat berishga roziman.
 - Maktabda beriladigan barcha retsept va retseptsiz dorilar yangi, ochilmagan va asl qadog'ida bo'lishi kerak. Farzandim maktab kunlarida foydalanishi uchun maktabni joriy, muddati o'tmagan dorilar bilan ta'minlayman.
 - Retsept bo'yicha dori qadog'i yoki flakoni dorixonaning asl yorig'iga ega bo'lishi kerak. Yoriqda quyidagilar ko'rsatilishi kerak: **1)** farzandimning ismi, **2)** farmatsevtning ismi va telefon raqami, **3)** farzandimning sog'liqni saqlash provayderi, **4)** sana, **5)** qayta to'ldirish soni, **6)** dori nomi, **7)** dozasi, **8)** dorining maqsadi, **9)** dorini qabul qilish usuli **10)** va boshqa ko'rsatmalar.
 - Farzandimning dorilari yoki sog'liqni saqlash provayderi ko'rsatmalaridagi har qanday o'zgarishlar haqida maktab hamshirasini/sog'liqni saqlash provayderini **darhol** xabardor qilishim kerak.
 - SBHC va uning farzandimga yuqoridagi tibbiy xizmatlarni ko'rsatishda ishtirok etgan xodimlari ushbu shakldagi ma'lumotlarning to'g'riligiga tayanadi.
 - Ushbu dorilarni qabul qilish uchun ruxsatnoma shaklini (MAF) imzolash orqali men SBHCga farzandimga diabet bilan bog'liq tibbiy xizmatlar ko'rsatishga ruxsat beraman. Ushbu xizmatlar SBHCda sog'liqni saqlash provayderi yoki hamshira tomonidan klinik baholash yoki fizik tekshiruvni o'z ichiga olishi mumkin, lekin ular bilan cheklanmaydi.
 - Ushbu MAF bo'yicha dorilarga ko'rsatma berish muddati farzandimning o'quv yilining oxirida tugaydi, yozgi sessiyani o'z ichiga olishi mumkin yoki men maktab hamshirasi/SBHC provayderiga yangi MAF ni berganimda tugaydi, bu qaysi holat birinchi bo'lishiga bog'liq. Ushbu dori ko'rsatmasining amal qilish muddati tugagach, men maktab hamshirasiga/SBHC provayderiga farzandimning shifokori tomonidan yozilgan yangi ruxsatnomani beraman.
 - Maktab va Ta'lim boshqarmasi (DOE) farzandim qonidagi qand miqdorini xavfsiz tekshirilishiga ishonch hosil qiladi.
 - Ushbu shakl mening roziligim va ushbu shaklda tasvirlangan qandli diabetni davolash xizmatlarini olishga bo'lgan so'rovimni tashkil etadi va uni to'g'ridan-to'g'ri maktabga topshirish mumkin. Bu OSH tomonidan so'ralgan xizmatlarga rozilik hisoblanmaydi. Agar OSH ushbu xizmatlarni taqdim etishga rozi bo'lsa, farzandim yashash rejasiga muhtoj bo'lishi mumkin. Ushbu reja maktab tomonidan tuziladi.
 - Farzandimga g'amxo'rlik yoki davolanishni ta'minlash uchun OSH farzandimning sog'lig'i, dorilari yoki davolanishi haqida zarur deb hisoblagan boshqa ma'lumotlarni olishi mumkin. OSH bu ma'lumotni farzandimga tibbiy yordam ko'rsatgan har qanday provayder, hamshira yoki farmatsevtidan olishi mumkin.

ESLATMA: Farzandingiz uchun dorilar va jihozlarni maktab sayohati kuni va darsdan tashqari mashg'ulotlar uchun yuborish tavsiya etiladi.

Qandli diabetga qarshi dori vositalarni qabul qilish shakli (DMAF) uchun OSH ning ota-onalar uchun ishonch telefoni raqami: 718-786-4933

DORILAR VA/YOKI MUOLAJALARNI MUSTAQIL QABUL QILISH UCHUN (FAQAT MUSTAQIL O'QUVCHILAR):

- Farzandim barcha tayyorgarlikdan o'tganini va mustaqil ravishda dorilarni qabul qilish va/yoki muolajalarni bajara olishini tasdiqlayman. Men farzandimning maktabda va sayohat paytida ushbu shaklda ko'rsatilgan dorilarni olib yurishiga, saqlashiga va mustaqil foydalanishiga rozilik beraman. Men yuqorida aytib o'tilganidek, ushbu dorilarni farzandimga flakon yoki qutilarda yuborish uchun javobgarman. Shuningdek, men farzandimning dori vositalaridan foydalanishini nazorat qilish va farzandimning maktabda ushbu dori vositasidan foydalanishining barcha natijalari uchun javobgarman. Maktab hamshirasi yoki SBHC tibbiy yordam ko'rsatuvchi provayderlari mening farzandim dorilarni olib yurishi va mustaqil qabul qilishi mumkinligini tasdiqlaydi. Shuningdek, men maktabga tushunarli yoriqli qutilar yoki shishalarda qo'shimcha dorilarni taqdim etishga ruxsat berishga roziman.
- Agar farzandim dorilarni vaqtincha olib yura olmasa va qabul qila olmasa, men maktab hamshirasi yoki tayyorgarlikdan o'tgan maktab xodimlariga shifokor ko'rsatmasiga binoan farzandimga glyukagon berishiga roziman.

OTA-ONA/VASIY IMZOSI QUYIDA

Ota-ona/Vasiyning bosma harflardagi ism-familiyasi	Ota-ona/Vasiyning A va B qism uchun imzosi	Imzolangan sana
Ota-ona/Vasiyning manzili	Ota-ona/Vasiyning elektron pochta manzili	
Shoshilinch kontakt raqamlar	Eng yaxshi kont. tel. raq.	Uy tel raq. Uyali tel. raq.
Muqobil shoshilinch kontaktning ismi va familiyasi	O'quvchi bilan aloqa	Kont. tel. raq.

For Office of School Health (OSH) Use Only

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:	