

শিক্ষার্থীর শেষ নাম	প্রথম নাম	জন্মতারিখ	লিঙ্গ <input type="checkbox"/> M <input type="checkbox"/> F	OSIS #
স্কুলের ATSDBN / নাম	ঠিকানা	বরো	ডিস্ট্রিক্ট	গ্রেড / ক্লাস

This is an optional form for small changes to a diabetes regimen during the school year. Please see 'Provider Guidelines for DMAF Completion' for more details.

**Change Student Skill Level:**

<b>Glucose Monitoring:</b> <input type="checkbox"/> Nurse-Dependent <input type="checkbox"/> Supervised <input type="checkbox"/> Independent	<b>Insulin Dosing &amp; Administration:</b> <input type="checkbox"/> Nurse-Dependent <input type="checkbox"/> Supervised <input type="checkbox"/> Independent*	_____ (Provider Initials)	<b>* I attest that the independent student</b> demonstrated ability to self-carry & self-administer the prescribed medication (excluding glucagon) effectively during school, field trips, and school sponsored events.
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**Change Blood Glucose (bG)/Sensor Glucose (sG) Monitoring Times:**

- PRN    Breakfast    Lunch    Snack    Gym    Dismissal  
 Discontinue all bG/sG monitoring at school, including PRN instructions

**Change CGM Brand/Model:** Name: \_\_\_\_\_  Use attached CGM grid

*\*If starting a CGM for the first time, please submit an updated DMAF.*

**Change Insulin Dosing:**

- Discontinue all rapid-acting insulin in school, including instructions to give correction doses PRN or in the setting of ketosis

**Change target blood glucose to:**

\_\_\_\_ mg/dl from \_\_\_\_ AM/PM to \_\_\_\_ AM/PM

\_\_\_\_ mg/dl from \_\_\_\_ AM/PM to \_\_\_\_ AM/PM

**Change insulin sensitivity factor (ISF) to:**

1: \_\_\_\_ mg/dl from \_\_\_\_ AM/PM to \_\_\_\_ AM/PM

1: \_\_\_\_ mg/dl from \_\_\_\_ AM/PM to \_\_\_\_ AM/PM

**Change insulin to carbohydrate ratio (I:C) to:**

1: \_\_\_\_ g from \_\_\_\_ AM/PM until \_\_\_\_ AM/PM or at  Breakfast    Lunch    Snack

1: \_\_\_\_ g from \_\_\_\_ AM/PM until \_\_\_\_ AM/PM or at  Breakfast    Lunch    Snack

**Change long-acting insulin at school:** Name: \_\_\_\_\_ Dose: \_\_\_\_ units Time: \_\_\_\_\_ **OR** pre-lunch

**Other Orders**


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

<b>Health Care Provider</b> Last Name (PLEASE PRINT)		First name		<b>Signature</b>		<b>Date</b>	
<b>Credentials:</b> <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA							
<b>Address</b> Street			City/State		ZIP	<b>Email</b>	
<b>NYS License # or NPI # (Required)</b>			Tel		Fax	CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.	