

Student Last Name	First name	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	OSIS #
School ATSDBN / Name	Address	Borough	District	Grade / Class

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

Change Insulin Dosing:

- Discontinue all rapid acting insulin in school, including instructions to give correction doses PRN or in the setting of ketosis
 Discontinue sliding scale(s), use ratios below

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).			
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.