NYC Health | Office of School Health

Forms submitted after June 1st may delay processing for new school year.

Diabetes Medication Administration Form

Provider Medication Order Form | School Year 2025-26

Please fax all DMAFs to 347-396-8932/8945

Orders written will be implemented when submitted and approved. If you wish to start order implementation in September 2025, please check here ☐

Student Last Name	First name	Date of Birth	Sex ☐M ☐F	OSIS #

School ATSDBN / Name	Address	Borough	District	Grade / Class

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/IM ☐ 0.5mg SC/IM	☐ 3mg Intranasal	☐ 0.6mg SC May 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
- ☐ NO GYM

SECTION C: Glucose Monitoring

C1. Glucose Monitoring Times	C2. Continuous Glucose Monitor Use *(Must complete Section G)*
☐ PRN ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ Dismissal ☐ No bG monitoring	☐ 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 D: Skill Level *(If incomplete or attestation not initialed, default is nurse dependent)*

D1. Glucose Monitoring	D2. Insulin Calculation & Administration	Skill Level: Skills include finger sticks, glucometer and/or CGM use insulin dose calculation, and insulin administration (only nurses or supervised/independent students may calculate/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 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 at PRN and ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ Dismissal
Recheck bG in 15 min or ____ min until bG > 70 mg/dl or _____ mg/dl

☐ For bG < _____ mg/dl, give ____ g rapid carbs at ☐ PRN ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ Dismissal
Recheck bG in 15 min or ____ min until bG > _____ mg/dl

E1b. Pre-Gym Hypoglycemia Orders

☐ For bG < _____ mg/dl, no gym
☐ 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 ____ g carb snack before dismissed
☐ For bG < _____ mg/dl, treat hypoglycemia PRN, call parent to pick up

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

*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 ☐ Smart Pen - use pen suggestions
☐ Pump (Brand) **If left blank, will use syringe/pen*

_____
**For iLet, must complete iLet Pump Orders Form*

F3. Insulin Pump Orders

☐ Student on FDA approved hybrid closed loop pump – basal rate variable per pump
☐ Follow pump recommendations for bolus doses
☐ 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. Concern for Pump Failure/Pump Dislodgement

☐ For bG > _____ mg/dl that has not decreased in ____ hrs after correction, consider pump failure and notify parents
☐ For suspected pump failure/dislodgement, SUSPEND pump and give rapid acting insulin by syringe/pen
☐ For pump failure/dislodgement, only give correction dose if > ____ hrs since last rapid acting insulin
☐ In the setting of pump failure/dislodgement, do not use the pump to calculate insulin correction doses

F5. Insulin Calculation Methods

F5a. Correction Dose Using: ☐ ISF ☐ Sliding Scale

F5b. Carb Coverage Using: ☐ I:C ☐ Sliding Scale ☐ Fixed Dose

F5c. Insulin Dosing for Meals:

	Meal		
Insulin Dose	Breakfast	Lunch	Snack
Carb Coverage Dose	☐	☐	☐
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-Food Insulin Administration

☐ If bG> _____ mg/dl, give correction dose pre-meal and carb coverage after meal
☐ Give insulin after: ☐ Breakfast ☐ Lunch ☐ Snack

Carb Coverage using I:C

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

Correction using ISF

$\frac{\text{bG – target bG}}{\text{ISF}}$ = 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 ____ g carbs

Time _____ to _____ ***OR*** Lunch
1 unit per ____ g carbs

Time _____ to _____ ***OR*** Snack
1 unit per ____ g 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 (*Provide additional sliding scales in Section I: Other Orders*)

Do **NOT** overlap ranges (e.g., enter 0-100, 101-200, etc.). If ranges overlap, the lower dose will be given. You must 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.

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
- ☐ ____ units for lunch
- ☐ ____ units for snack

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)

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** ☐ **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 ↗	If symptomatic, treat hypoglycemia per bG hypoglycemia plan. If asymptomatic, recheck in 15-20 min. If sG still <70 mg/dl, check bG.
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 > 2 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.

NYC Health Office of School Health

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Diabetes Medication Administration Form
Parent Consent Form | School Year 2025-26
Please fax all DMAFs to 347-396-8932/8945

Student Last Name	First name	Date of Birth	Sex ☐M ☐F	OSIS #

School ATSDBN / Name	Address	Borough	District	Grade / Class

PARENTS AND GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to the nurse/school-based health center (SBHC) provider giving my child's prescribed medicine, and the nurse/trained staff/SBHC provider checking their blood sugar and treating their low blood sugar based on the directions and skill level determined by my child's health care provider. These actions may be performed on school grounds or during school trips.
2. I also consent to any equipment needed for my child's medicine being stored and used at school.
3. I understand that:
   - I must give the school nurse/SBHC provider my child's medicine, snacks, equipment, and supplies and must replace such medicine, snacks, equipment and supplies as needed. The Office of School Health (OSH) recommends the use of safety lancets and other safety needle devices and supplies to check my child's blood sugar levels and give insulin.
   - I consent to my child carrying and storing their medication/supplies in school and on trips as outlined in their 504 meeting.
   - All prescription and "over the counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.
     - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: **1)** my child's name, **2)** pharmacy name and phone number, **3)** my child's health care provider's name, **4)** date, **5)** number of refills, **6)** name of medicine, **7)** dosage, **8)** when to take the medicine, **9)** how to take the medicine and **10)** any other directions.
   - I must **immediately** tell the school nurse/SBHC provider about any change in my child's medicine or the health care provider's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this Medication Administration Form (MAF), I authorize OSH to provide diabetes-related health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care provider or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse/SBHC provider a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse/ SBHC provider a new MAF written by my child's health care provider.
   - OSH and the Department of Education (DOE) make sure that my child can safely test their blood sugar.
   - This form represents my consent and request for the diabetes services described on this form, and may be sent directly to OSH. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment for my child, OSH may obtain any other information they think is needed about my child's medical condition, medication, or treatment. OSH may obtain this information from any health care provider, nurse, or pharmacist who has given my child health services.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

OSH Parent Hotline for questions about the Diabetes Medication Administration Form (DMAF): 718-786-4933

FOR SELF-ADMINISTRATION OF MEDICINE AND/OR PROCEDURES (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine and/or perform procedures on their own. I consent to my child carrying, storing, and giving themself the medicine prescribed on this form in school and on trips. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use and for all results of my child's use of this medicine in school. The school nurse or SBHC providers will confirm my child's ability to carry and give themself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child glucagon if prescribed by their health care provider if my child is temporarily unable to carry and take medicine.

PARENT / GUARDIAN SIGN BELOW

Print Parent / Guardian's Name	**Parent / Guardian's Signature for Parts A & B**	**Date Signed**

Parent / Guardian's Address		Parent / Guardian's Email	
Emergency Contact Numbers	Best Contact Tel No.	Home Tel No.	Cell Phone No.
Alternate Emergency Contact's Name		Relationship to Student	Contact Tel No.

NYC Health Office of School Health

Diabetes Medication Administration Form General DMAF Addendum | School Year 2025-26

Optional form for small changes to diabetes regimen during school year - please see Provider Guidelines for more details

Please fax all DMAFs to 347-396-8932/8945

Student Last Name	First name	Date of Birth	Sex ☐M ☐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: ☐ 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.

NYC Health | Office of School Health

Diabetes Medication Administration Form
iLet Insulin Pump Orders | School Year 2025-26
Please fax all DMAFs to 347-396-8932/8945

Student Last Name	First name	Date of Birth	Sex ☐ M ☐ F	OSIS #

School ATSDBN / Name	Address	Borough	District	Grade / Class

These orders must be submitted with Parts A and B of the SY 25-26 DMAF. The iLet pump does not deliver correction dose boluses or use carb ratios. If you would like the school nurse to use the iLet pump, you must provide carbohydrate ranges for "less", "usual", and "more" carbohydrates ***or*** select one option the nurse should use for each meal.

GLUCOSE TARGET

Usual (120 mg/dl) **or** ☐ Lower (110 mg/dl) ☐ Higher (130 mg/dl)

MEAL ANNOUNCEMENTS

☐ **Minimum carbohydrate content to announce meal or snack:** 15 g or _____ g carbs

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

	Meal Size		
Meal Type	**Less***	**Usual**	**More**
Breakfast	☐	☐	☐
Lunch	☐	☐	☐

** If the "Less" option is not available, do not announce the meal/snack*

OR

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

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

Announce snacks as:

☐ "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

General iLet Insulin Pump Orders

Do not announce meals more than 15 min or _____ min prior to eating.
Do not announce meals if it has been more than 30 min or _____ min since the student started eating.
☐ If the student eats more carbohydrates after a meal announcement, announce again for the additional carbs. Only consider the amount of additional carbs when choosing the additional meal size; do not include carbs that were already announced.

ACTIVITY PARAMETERS

☐ Disconnect pump 60 min or _____ min before starting activity and reconnect immediately or _____ min after activity
☐ If lunch is immediately before activity, do not disconnect pump until activity starts
☐ **After** disconnecting pump for activity, give _____ g of uncovered carbs pre-activity if bG < _____ mg/dl
☐ Do not disconnect pump or give uncovered carbohydrates prior to activity

PUMP FAILURE ORDERS

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.

Target bG = _____ mg/dl
ISF 1: _____ mg/dl
I:C 1: _____ g

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: ☐ 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.