

Forms submitted after June 1<sup>st</sup> may delay processing for new school year.

Please fax all DMAFs to 347-396-8932/8945 or email to OshDMAF@health.nyc.gov

Orders written will be implemented when submitted and approved. If you wish to start order implementation in September 2026, please check here

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

**HEALTH CARE PROVIDER COMPLETES BELOW [Please see "Provider Guidelines for DMAF Completion"]**

**SECTION A: Diagnosis**

<b>A1. Diagnosis</b> Diabetes Mellitus <input type="checkbox"/> Type 1 or <input type="checkbox"/> Type 2 or <input type="checkbox"/> Other: _____ Dx Date ____/____/____	<b>A2. Recent A1c</b> Date ____/____/____ Result ____%
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**SECTION B: Emergency Orders**

<p align="center"><b>B1. Severe Hypoglycemia</b> <b>ADMINISTER GLUCAGON AND CALL 911</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><b>Glucagon</b> <input type="checkbox"/> 1mg SC/IM <input type="checkbox"/> 0.5mg SC/IM</td> <td style="width:25%;"><b>GVOKE</b> <input type="checkbox"/> 1mg SC <input type="checkbox"/> 0.5mg SC</td> <td style="width:25%;"><b>Baqsimi</b> <input type="checkbox"/> 3mg Intranasal</td> <td style="width:25%;"><b>Zegalogue</b> <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>	<b>Glucagon</b> <input type="checkbox"/> 1mg SC/IM <input type="checkbox"/> 0.5mg SC/IM	<b>GVOKE</b> <input type="checkbox"/> 1mg SC <input type="checkbox"/> 0.5mg SC	<b>Baqsimi</b> <input type="checkbox"/> 3mg Intranasal	<b>Zegalogue</b> <input type="checkbox"/> 0.6mg SC Repeat in 15 min PRN	<p align="center"><b>B2. Risk for Diabetic Ketoacidosis (DKA)</b> <b>CALL 911 IF POSITIVE KETONES AND VOMITING, UNABLE TO TAKE PO, ALTERED MENTAL STATUS, OR BREATHING CHANGES</b></p> <p>Test ketones if any of the following:          • vomiting          • fever <math>\geq</math> 100.5 F          • bG <math>&gt;</math> ____ mg/dl for the  <input type="checkbox"/> FIRST OR <input type="checkbox"/> SECOND time that day, <math>\geq</math> 2 hrs apart</p> <p>If ketones small or trace, give water, re-test ketones &amp; 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 <math>\geq</math> 2 hrs or ____ hrs since last rapid acting insulin (see F6)  <input type="checkbox"/> NO GYM OR PHYSICAL ACTIVITY</p>
<b>Glucagon</b> <input type="checkbox"/> 1mg SC/IM <input type="checkbox"/> 0.5mg SC/IM	<b>GVOKE</b> <input type="checkbox"/> 1mg SC <input type="checkbox"/> 0.5mg SC	<b>Baqsimi</b> <input type="checkbox"/> 3mg Intranasal	<b>Zegalogue</b> <input type="checkbox"/> 0.6mg SC Repeat in 15 min PRN		

**SECTION C: Skill Level (If incomplete or attestation not initialed, default is nurse dependent)**

<b>C1. Glucose Monitoring</b> PICK ONE	<input type="checkbox"/>	<b>C2. Insulin Calculation &amp; Administration</b> PICK ONE	<input type="checkbox"/>	<b>Skill Level:</b> Skills include finger sticks, glucometer and/or CGM use, insulin dose calculation, and insulin administration* *Only nurses or supervised/independent students may administer insulin  <b>Nurse-Dependent:</b> Nurse or trained staff must perform <b>Supervised:</b> Student to perform with adult supervision <b>Independent:</b> Student carries supplies & self-administers  <b>FOR INDEPENDENT MEDICATION ADMINISTRATION: I attest that the independent student demonstrated ability to self-carry &amp; self-administer the prescribed medication (excluding glucagon) effectively during school, field trips, and school sponsored events.</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Provider Initials _____

**SECTION D: Glucose Monitoring**

<b>D1. Glucose Monitoring Times</b> 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	<b>D2. Continuous Glucose Monitor Use</b> (Must complete Section G) <input type="checkbox"/> Use CGM readings for glucose monitoring <input type="checkbox"/> Use CGM readings for insulin dosing  <b>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.</b>
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**SECTION E: Glucose Monitoring Parameters**

<p><b>E1. Hypoglycemia</b> (Provide additional hypoglycemia instructions in Section I: Other Orders)</p> <p><b>E1a. Oral Hypoglycemia Treatment</b>  <input type="checkbox"/> For bG <math>&lt;</math> 70 mg/dl or <math>&lt;</math> ____ mg/dl, give 15 g or ____ g rapid carbs PRN. Recheck bG in 15 min or ____ min until bG <math>&gt;</math> 70 mg/dl or ____ mg/dl.  <input type="checkbox"/> For bG <math>&lt;</math> ____ mg/dl, give ____ g rapid carbs PRN. Recheck bG in 15 min or ____ min until bG <math>&gt;</math> 70 mg/dl or ____ mg/dl.</p> <p><b>E1b. Pre-Gym/Physical Activity Hypoglycemia Orders</b>  <input type="checkbox"/> For bG <math>&lt;</math> ____ mg/dl, no gym or physical activity  <input type="checkbox"/> For bG <math>&lt;</math> ____ mg/dl, treat hypoglycemia then give uncovered snack*  <input type="checkbox"/> For bG <math>&lt;</math> ____ mg/dl, give uncovered snack*</p> <p><b>E1c. Pre-Dismissal Hypoglycemia Orders</b>  <input type="checkbox"/> For bG <math>&lt;</math> ____ mg/dl, treat hypoglycemia PRN, and give ____ g carb snack before dismissed  <input type="checkbox"/> For bG <math>&lt;</math> ____ mg/dl, treat hypoglycemia PRN, call parent to pick up</p>	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
<p><b>E2. Hyperglycemia</b>  <input type="checkbox"/> For bG <math>&gt;</math> ____ 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 <math>&gt;</math> ____ mg/dl PRN, give insulin correction if <math>\geq</math> 2 hrs or ____ hrs since last rapid acting insulin</p>	bG "HI" reading = 500 mg/dl or ____ mg/dl

**SECTION F: Insulin Orders**

<p><b>F1. Insulin Name</b> _____  <input type="checkbox"/> No insulin in school                  * May substitute Novolog with Admelog/Humalog</p> <p><b>F2. Insulin Delivery Method</b>  <input type="checkbox"/> Syringe/Pen <input type="checkbox"/> Smart Pen - use app recommendations  <input type="checkbox"/> Pump (Brand) *If left blank, will use syringe/pen                   *For iLet, must complete iLet Pump Orders Form</p> <p><b>F3. Insulin Pump Orders</b>                  *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</p> <p><b>F4. Concern for Pump Failure/Pump Dislodgement</b>  <input type="checkbox"/> For bG <math>&gt;</math> ____ 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 <math>\geq</math> 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</p>	<p><b>F5. Insulin Calculation Methods</b>  <b>F5a. Carb Coverage Using:</b> <input type="checkbox"/> I:C <input type="checkbox"/> Sliding Scale <input type="checkbox"/> Fixed Dose  <b>F5b. Correction Dose Using:</b> <input type="checkbox"/> ISF <input type="checkbox"/> Sliding Scale  <b>F5c. Insulin Dosing for Meals:</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <th colspan="3">Meal</th> </tr> <tr> <td>Insulin Dose</td> <td>Breakfast</td> <td>Lunch</td> <td>Snack</td> </tr> <tr> <td>Carb Coverage Dose</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Correction Dose</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p>When carb coverage and correction doses are given at the same time, correction dose will be added when bG <math>&gt;</math> target <b>and</b> <math>\geq</math> 2 hrs or ____ hrs since last rapid acting insulin unless otherwise specified</p> <p><b>F5d. Exceptions to Pre-Meal Insulin Administration</b>  <input type="checkbox"/> Give insulin after: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack  <input type="checkbox"/> If bG <math>&gt;</math> target bG or ____ mg/dl, give correction dose pre meal and carb coverage after meal</p> <p><b>Carb Coverage using I:C</b>  <math>\frac{\# \text{ g carb in meal}}{\text{I:C}} = X \text{ units insulin}</math></p> <p><b>Correction using ISF</b>  <math>\frac{\text{bG} - \text{target bG}}{\text{ISF}} = Y \text{ units insulin}</math></p> <p>Round DOWN insulin dose to closest 0.5 unit for syringe/pen, or nearest whole unit if syringe/pen doesn't have 1/2 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.</p>		Meal			Insulin Dose	Breakfast	Lunch	Snack	Carb Coverage Dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Correction Dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>F6. Insulin Dose Calculation Ratios</b>                  Times will be 7am - 4pm if not specified  <b>F6a. Target bG</b>                  ____ mg/dl from time ____ to ____                  ____ mg/dl from time ____ to ____</p> <p><b>F6b. Insulin Sensitivity Factor (ISF)</b>                  1 unit decreases bG by:                  ____ mg/dl from time ____ to ____                  ____ mg/dl from time ____ to ____</p> <p><b>F6c. Insulin:Carb Ratio (I:C)</b>                  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</p>
	Meal																	
Insulin Dose	Breakfast	Lunch	Snack															
Carb Coverage Dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
Correction Dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															

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Student Last Name	First name	Date of Birth	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)

F7a. Correction Dose		F7b. Carb Coverage PLUS Correction Dose		
bG (mg/dl)	Units	bG (mg/dl)	Units	Use For:
Zero	0	Zero		<input type="checkbox"/> Breakfast
-		-		<input type="checkbox"/> Lunch
-		-		<input type="checkbox"/> Snack
-		-		<input type="checkbox"/> See attached
-		-		
-		-		
-		-		

**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 <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.

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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

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

- 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.
- I also consent to any equipment needed for my child's medicine being stored and used at school.
- 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 themselves 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 themselves 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	
<b>Emergency Contact Numbers</b>	Best Contact Tel No.	Home Tel No.
Alternate Emergency Contact's Name	Relationship to Student	Cell Phone No.
		Contact Tel No.

**For Office of School Health (OSH) Use Only**

OSIS Number:

Received by: Name

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed by: Name

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

504     IEP     Other

Referred to School 504 Coordinator     Yes     No

Services provided by:     Nurse/NP

OSH Public Health Advisor (for supervised students only)

School Based Health Center

Signature and Title (RN OR SMD):

Date School Notified & Form Sent to DOE Liaison \_\_\_\_/\_\_\_\_/\_\_\_\_

Revisions as per OSH contact with prescribing health care practitioner

Clarified     Modified

Notes

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

**These orders must be submitted with Parts A and B of the SY 26-27 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)  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
- Select meal size based on carbohydrate content** in meal. You may use large ranges, e.g., 15-100 g carbs

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

**OR**

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

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

**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**

- 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**

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: <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.



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.