



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 ____ . ____ %
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SECTION B: Emergency Orders

B1. Severe Hypoglycemia ADMINISTER GLUCAGON AND CALL 911				B2. Risk for Diabetic Ketoacidosis (DKA) CALL 911 IF POSITIVE KETONES AND VOMITING, UNABLE TO TAKE PO, ALTERED MENTAL STATUS, OR BREATHING CHANGES	
Glucagon ☐ 1mg SC/IM ☐ 0.5mg SC/IM	GVOKE ☐ 1mg SC/IM ☐ 0.5mg SC/IM	Baqsimi ☐ 3mg Intranasal	Zegalogue ☐ 0.6mg SC May repeat in 15 min PRN	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
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.					

SECTION C: Glucose Monitoring

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

C1. Glucose Monitoring Times ☐ PRN ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ Dismissal ☐ No bG monitoring	C2. Continuous Glucose Monitor Use (Must complete Section G) ☐ 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.	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		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		
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				
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	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: <table><tr><td></td><td colspan="3">Meal</td></tr><tr><td>Insulin Dose</td><td>Breakfast</td><td>Lunch</td><td>Snack</td></tr><tr><td>Carb Coverage Dose</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Correction Dose</td><td>☐</td><td>☐</td><td>☐</td></tr></table>		Meal			Insulin Dose	Breakfast	Lunch	Snack	Carb Coverage Dose	☐	☐	☐	Correction Dose	☐	☐	☐	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
	Meal																	
Insulin Dose	Breakfast	Lunch	Snack															
Carb Coverage Dose	☐	☐	☐															
Correction Dose	☐	☐	☐															
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	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																	
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	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 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.																	
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																		

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., 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.

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)

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
-		
-		
-		

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.

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:

- 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		
Emergency Contact Numbers	Best Contact Tel No.	Home Tel No.	Cell Phone No.
Alternate Emergency Contact's Name	Relationship to Student	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