**Carb Coverage:**

- T2DM – no bG monitoring in school
- No Insulin at Snack
- For bG > mg/dl give gm rapid carbs at
- For bG < mg/dl treat hypoglycemia and then give snack
- Give insulin correction dose if > 2 hrs or _____hours since last rapid acting insulin.
- Give insulin correction dose if > 2 hrs or _____hours since last rapid acting insulin.

**Skill Level:**

- BLOOD GLUCOSE MONITORING [See Part B for CGM readings]
- T2DM – no bG monitoring in school
- 15 gm rapid carbs = 1 glucose
gel tube = 4oz. juice
- For bG > mg/dl before dismissal, give correction dose pre-meal and carb coverage after meal
- For bG or bG values < mg/dl treat for hypoglycemia if needed, and give gm carb snack before dismissed
- For bG < mg/dl after correction, consider pump failure and notify parents.

**Insulin Calculation Directions:** (give number, not range)

- 1 unit decreases bG by ________mg/dl (time ________to________)
- 1 unit decreases bG by ________mg/dl (time ________to________)

**Insulin Sensitivity Factor (ISF):**

- 1 unit decreases bG by ________mg/dl (time ________to________)

**Insulin to Carb Ratio (IC):**

- 1 unit per ________gms carbs
- Snack OR time ________to________
- 1 unit per ________gms carbs
- Lunch OR time ________to________
- 1 unit per ________gms carbs

**Incretin Modifiers:**

- 1 unit decreases bG by ________mg/dl (time ________to________)
- 1 unit decreases bG by ________mg/dl (time ________to________)
CONTINUOUS GLUCOSE MONITORING (CGM) ORDERS [Please see ‘Provider Guidelines for DMAF Completion’]

☐ Use CGM readings - For CGM’s used to replace finger stick bG readings, only devices FDA approved for use and age may be used within the limits of the manufacturer’s protocol. (sG = sensor glucose). You must include name and model of the CGM in use.

Name and Model of CGM:

For CGM used for insulin dosing: finger stick bG will be done when: the symptoms don’t match the CGM readings; 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) ☐ CGM to be used for insulin dosing and monitoring - must be FDA approved for use and age

sG Monitoring Specify times to check sensor reading [ ] Breakfast  [ ] Lunch  [ ] Snack  [ ] Gym  [ ] PRN (If none checked, will use bG monitoring times)

☐ For sG <70mg/dl check bG and follow orders on DMAF, unless otherwise ordered below. Use CGM grid below OR ☐ See attached CGM instruction

Use sliding scale for correction AND at meals ADD:

Round insulin dosing to nearest whole unit: 0.51-1.50u rounds to 1.00u.
Round insulin dosing to nearest half unit: 0.26-0.75u rounds to 0.50u (must have half unit syringe/pen).

Long-acting insulin given in school – Insulin Name:

Dose: ________ units Time __________ or ☐ Lunch

ADDITIONAL INFORMATION

Is the child using altered or non-FDA approved equipment? ☐ Yes or ☐ No  [Please note that New York State Education laws prohibit nurses from managing non-FDA devices. Please provide pump failure and/or back up orders on DMAF Part A Form.]

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

Health Care Practitioner LAST  ___________ FIRST ___________ SIGNATURE ___________ DATE ___________

PLEASE PRINT check one ☐ MD ☐ DO ☐ NP ☐ PA

Address ___________ CITY/STATE ___________ ZIP ___________ Email ___________

NYS License # (Required) ___________ Tel ___________ Fax ___________

CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.
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