

## ভায়াবেটিস মেডিকেশন অ্যাডমিনিস্ট্রেশন ফর্ম [পার্ট A]

সেবা প্রদানকারীর ঔষধ প্রদান সংক্রান্ত নির্দেশনার ফর্ম । 2023-24 শিক্ষা বছর

শেষ তারিখ: পহেলা (1) জুন পহেলা (1) জুনের পর কর্মগুলো জমা দিলে নতুন শিক্ষা বছরের জন্য প্রক্রিয়াকরণ করতে দেবি হতে পারে।

जानको करन अंकन DMAE 247-206-9022/9045 न्यान क्यांचा करू

আঞ্জাক্ষণ করতে গোর হতে গারে। অনুমার করণ DMAE 347-390-8932/8935 গররে পাস্ত করণ													
<b>শিক্ষার্থীর</b> শেষ নাম:	র শেষ নাম: প্রথম নাম:					জন্মতারিখ:			OSIS#				
<b>জুলের</b> ATSDBN/নাম: ঠিকানা:					বরো: DOE fo			ডিস্ট্রিক্ট:	গ্রেড:	ক্লাস:			
	HEALTH C	ARE PRA	ACTITI	ONER COMPLETES E	BELOW [Plea	ase see 'Provider Guidelii	nes for D	MAF Compl	etion']				
☐ Type 1 Diabetes ☐	Type 2 Diabetes	□ Non-T	Гуре 1/1	Гуре 2 Diabetes	Recent A1c								
☐ Other Diagnosis:						Date	/ / Result . %						
	implemented v	vhen subr	mitted a	and approved If you wisl	h to delay ord	ers for September 2023 ple	ase chec	ck here □		<del></del>			
Gradio William Bo	pioinontou t	viioii oubi			RGENCY OF		400 0	JK 11010 🗀					
	Severe Hy				Risk for Ketones or Diabetic Ketoacidosis (DKA)								
Glucagon	minister Gluca GVOKE	gon and ( Bagsir		111 Zegalogue	☐ Test ketones if bG > mg/dl or if vomiting, or fever > 100.5 F								
	□ 1 mg	□ 3 mg		□ 0.6 mg SC	OR  ☐ Test ketones if bG > mg/dl for the 2nd time that day (at least 2 hrs. apart), or								
□mg	□mg	Intranasa	al	May repeat in 15 min if	if vomiting or	fever > 100.5 F				1 //			
SC/IM	SC/IM			needed		trace give water; re-test keto				.i			
is unknown. Turn onto				ity to swallow EVEN if bG	<ul> <li>✓ If ketones are moderate or large, give water, Call parent and Endocrinologist □ NO G</li> <li>✓ If ketones and vomiting, unable to take PO and MD not available, CALL 911</li> </ul>								
chosen, school staff wi					☐ Give insulin correction dose if > 2 hrs or hours since last rapid acting insulin.								
directed.				CKII I I EV				nours sirioc iac	таріа асп	ig madim.			
Blood Glucose (bG) N	onitorina Skill	Level	Insulin	Administration Skill Lev		lete, will default to nurse-depende	-	n / Salf-admir	nietor	1			
□ Nurse/adult must ch	eck bG		□ Nurs	e-Dependent Student: nur		(MUST initial attestation).	nt Self carry / Self-administer ). I attest that the independent						
<ul><li>☐ Student to check bG</li><li>☐ Student may check b</li></ul>	•			ster medication	loulates and		bility to self-administer the prescribed lucagon) effectively during school,						
Diddent may check t	o without super			ervised student: student ca ministers, under adult supe		field trips and school spor							
		1	BLOO	D GLUCOSE MONITO	RING [See F	Part B for CGM reading	s]			•			
				for treatment and/or insulin	,		Gym						
Hypoglycemia Check all boxes neede				less noted here	insulin after $\square$	Breakfast □ Lunch □	Snack	☐ Give Snac	k before gy	m			
				at □ Breakfast □ Lunch □	□ Snack □ Gy	m □ PRN				– no bG monitoring			
					I <mg and="" bg="" carbs="" dl="" repeat="" retesting="" until="">mg/dl</mg>					or insulin in school			
					n □ Snack □ Gym □ PRN				15 gm rapid carbs = 4				
· ·	-					retesting until bG >m			-	tabs = 1 glucose			
□ For bG <mg <b="" <mg="" and="" bg="" dl="" for="" give="" gym="" hypoglycemia="" no="" pre-gym="" pre-gym,="" prn="" snack="" then="" treat="" □="">gel tube = 4oz. juice</mg>							= 4oz. juice						
Mid-Range Glycemia   Insulin is given before food unless noted here   Give insulin after   Breakfast   Lunch   Snack   Give Snack before gym if bG < mg/dl								Ĺ					
Mid-Range Glycemia	Insulin is give	en before f	food unl	less noted here □ Give ins	sulin after □ B	reakfast □ Lunch □	Snack	_	before gyn	n if bG <mg dl<="" td=""></mg>			
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Hyperglycemia  For bG  For bG >  Check bG or Sensor For sG or bG values For sG  Insulin Name  *May substitute Novolo  No Insulin in school  Delivery Method  Syringe/Pen Sma  Pump (Brand)  For Pumps: Student on FDA appump-basal rate variabe suspend/disconned Suspend pump for responding to treatmer Activity Mode (HC Start minutes price	Insulin is give ng/dl pre-gym, it _mg/dl PRN, r Glucose (sG) <mg a="" bg="" cloe="" d="" e="" exercise="" for="" for<="" formin="" g="" gym="" humalog="" hybrid="" insulin="" no="" not="" nypoglycemia="" pen="" per="" pump="" pump.="" pumps):="" r="" roved="" rt="" t="" td="" the="" to="" use="" with="" –=""><td>en before for NO GYM Give ins before di la treat for values  VAdmelog t Snack  sed loop  tmin</td><td>sulin co ismissa ior hypo &lt;</td><td>  Insulin Calculation Me   Give on Me   Give</td><td>sulin after</td><td>reakfast □ Lunch □ Snack For bG mence last rapid acting insulin □ Give content carb snack before dismissiff needed, and do not send of the send of the</td><td>Insulin  Insulin  Snack</td><td>Give Snack  ng "High" use  ose pre-meal a  ss transit, pare  Calculation E  only one given, to  oG =r  Sensitivity F  decreases bG  decreases bG  n to Carb Ratio  OR time  or continue  or continue</td><td>bG of 500 of and carb co ent to pick to Directions:  Dire</td><td>ormg/dl  verage after meal  up from school.  (give number, not am to 4pm if not  to) mg/dl) mg/dl) mg/dl)</td></mg>	en before for NO GYM Give ins before di la treat for values  VAdmelog t Snack  sed loop  tmin	sulin co ismissa ior hypo <	Insulin Calculation Me   Give on Me   Give	sulin after	reakfast □ Lunch □ Snack For bG mence last rapid acting insulin □ Give content carb snack before dismissiff needed, and do not send of the	Insulin  Snack	Give Snack  ng "High" use  ose pre-meal a  ss transit, pare  Calculation E  only one given, to  oG =r  Sensitivity F  decreases bG  decreases bG  n to Carb Ratio  OR time  or continue  or continue	bG of 500 of and carb co ent to pick to Directions:  Dire	ormg/dl  verage after meal  up from school.  (give number, not am to 4pm if not  to) mg/dl) mg/dl) mg/dl)			
Hyperglycemia  For bG  For bG >  Check bG or Sensor For sG or bG values For sG  Insulin Name  *May substitute Novolo  No Insulin in school  Delivery Method  Syringe/Pen Sma  Pump (Brand)  For Pumps: Student on FDA app pump-basal rate variab suspend/disconnect Suspend pump for responding to treatment Activity Mode (HC Start minutes price duration (DEFAULT 1 following exercise)  Carb Coverage:	Insulin is give ng/dl pre-gym, it _mg/dl PRN, r Glucose (sG) < _mg/d	en before for NO GYM Give ins before di la treat for values  VAdmelog t Snack  sed loop  tmin	sulin co ismissa ior hypo <	Insulin Calculation Me   Give insulin Calculation Me   Carb coverage ONL   Carb coverage Plus at least 2 hrs or hrs   Breakfast   Lun   Correction dose Calcu   Fixed Dose (see Off   Sliding Scale (See F   If gym/recess is imm gm carbs from   Additional Pump Instr   Follow pump recommendation   For bG > mg/rafter correction, conside   For suspected pump acting insulin by syringe   For pump failure hrs since last ra	sulin after	reakfast □ Lunch □ Snack For bG mence last rapid acting insulin □ Give control and contro	Insulin Target I Insulin I unit (time Insulin I unit (time I unit Insulin I unit I uni	Give Snack  ng "High" use  ose pre-meal a ss transit, pare  Calculation I only one given, to  oG =r  Sensitivity F  decreases bG  decreases bG  n to Carb Ratio  OR time unit per unit per unit per unit per unit per	bG of 500 of and carb colorent to pick	ormg/dl  verage after meal  up from school.  (give number, not am to 4pm if not to) to) mg/dl) mg/dl)  os			
Hyperglycemia  For bG  Check bG or Sensor For sG or bG values For sG or bG values  For sG or bG values  *May substitute Novolo  No Insulin in school  Delivery Method  Syringe/Pen Charles  Pump (Brand)  For Pumps: Student on FDA appump-basal rate variab Suspend/disconned Suspend pump for responding to treatmer Activity Mode (HC Startminutes priduration (DEFAULT 1 following exercise)	Insulin is give ng/dl pre-gym, ing/dl pre-gym, ing/dl pre-gym, ing/dl pre-gym, ing/dl pre-gym, ing/dl pre-gym, ingline	en before for NO GYM Give ins before di la treat for values  Admelog t Snack  sed loop  otmin and 2 hrs	sulin co ismissa ior hype <	Insulin Calculation Me   Give insulin Calculation Me   Carb coverage ONL   Carb coverage Plus at least 2 hrs or hrs   Breakfast   Lun   Correction dose Calcu   Fixed Dose (see Off   Sliding Scale (See F   If gym/recess is imm gm carbs from   Additional Pump Instr   Follow pump recommendation   For bG > mg/rafter correction, conside   For suspected pump acting insulin by syringe   For pump failure hrs since last ra	sulin after	reakfast □ Lunch □ Snack For bG mence last rapid acting insulin □ Give content carb snack before dismissiff needed, and do not send of the sast □ Lunch □ Snack fast □ Lunch □ S	Insulin Target I Insulin I unit (time Insulin I unit (time I unit Insulin I unit I uni	Give Snack  ng "High" use  ose pre-meal a  ss transit, pare  Calculation E  only one given, to  oG =r  Sensitivity F  decreases bG  decreases bG  n to Carb Ratio  OR time  or continue  or continue	bG of 500 of and carb colorent to pick	ormg/dl  verage after meal  up from school.  (give number, not am to 4pm if not to) to) mg/dl) mg/dl)  os			



# শেষ তারিখ: পহেলা (1) জুন পহেলা (1) জুনের পর ফর্মগুলো জমা দিলে নতুন

ভায়াবেটিস মেডিকেশন অ্যাডমিনিস্ট্রেশন ফর্ম [পার্ট B] সেবা প্রদানকারীর ঔষধ প্রদান সংক্রান্ত নির্দেশনার ফর্ম। 2023-24 শিক্ষা বছর অনুগ্রহ করে সকল DMAF 347-396-8932/8945 নম্বরে ফ্যাক্স করুন

শিক্ষা বছরের জন্য প্রক্রিয়াকরণ করতে দেরি হতে পারে।														
শিক্ষার্থীর শেষ নাম			প্রথম নাম							C	SIS#			
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)								dings						
□ CGM to be used for insulin dosing and monitoring - <b>must be FDA approved for use and age sG Monitoring</b> Specify times to check sensor reading □ Breakfast □ Lunch □ Snack □ Gym □ PRN [ <i>if none checked, will use bG monitoring times</i> ]  For sG <70mg/dL check bG and follow orders on DMAF, unless otherwise ordered below. Use CGM grid below OR □ See attached CGM instruction														
CGM reading	GM reading Arrows			Action ☐ use < 80 mg/dl instead of < 70 mg/dl for grid action plan										
sG < 60 mg/dl	ng/dl Any arrows				Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.									
sG 60-70 mg/dl and $\downarrow$ , $\downarrow$ , $\searrow$ or $\rightarrow$			Treat hypoglycemia per bG hypoglycemia plan; Recheck in 15-20 min. If still < 70 mg/dl check bG.											
sG 60-70 mg/dl and ↑, ↑↑, or ₹			If symptomatic, treat hypoglycemia per bG hypoglycemia plan; if not symptomatic, recheck in 15-20 minutes. If still <70 mg/dl check bG.											
sG < 70 mg/dl sG < 120 mg/dl	nre-gym or		Any arro						for insulin dosing carbs. If gym or recess is imn	nediately after	lunch subtract 1	5 ame of carbo	from lunch	
recess	pre-gym or		anu ţ, ţ.	<b>+</b>		carb calc		ou o	arbs. If gyffi of recess is iffili	nediately after	iunon, subtract i	o gillo di carbo	s iroin lunch	
sG ≥ 250			Any arro			1			or treatment and insulin dos	ing				
☐ For student	using CGM,	wait 2 ho	urs after r	meal before			71 07							
					PAR	ENTAL II	NPUT INTO	) IN	SULIN DOSING					
Parent(s)/Guare Taking the pare				se will dete	mine the i				e nurse with information rele e ordered by the health care					
							i	NE c	option below				•	
1. 🗆 N on p	lurse may ad parental inpu	djust calc it and nui	ulated do	se up or do ment.	wn up to	uni	ts based		2. ☐ Nurse may adjus of the prescribed do				% ment.	
	MUST COMPLETE: Health care practitioner 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 practitioner to see if the school orders need to be revised.													
			SI IDING	SCALE				_		OPTION	L ORDERS			
dose will be given. Use pre-treatment bG to calculate insulin dose unless other orders.							g to nearest whole unit: 0.51-1.50u rounds to 1.00u. g to nearest half unit: 0.26-0.75u rounds to 0.50u (must have							
□ Lunch □ Snack	bG	Units In	·	Other Time :		bG	bG Units Insulin ☐ Use sliding scale for correction AND at meal							
<ul><li>☐ Breakfast</li><li>☐ Correction</li></ul>	Zero -			l Lunch l Snack	Zer	units for lund units for breat		for lunch; for breakfast						
Dose	-		□ Snack □ Breakfast			- (sliding scale must be marke		narked as corre	d as correction dose only)					
	-		☐ Correction ☐ ☐ Dose			-		☐ Long-acting insulin giv	sulin given in school – Insulin Name:					
	-		Dose			-			Dose:units Time		or □ Lunch			
OTUED ODD	-							<u>ا</u> ا						
OTHER ORD	EKS								OME MEDICATIONS edication	Dose	☐ None Frequency	Time	Route	
								Ins	sulin					
								Ot	ther					
						ADE	NTIONAL II	NE	OPMATION					
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.														
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 Prac	titioner LAST			FIRST			NATURE		•	. , ,	DATE			
PLEASE PRINT Address STREET		□MD		DO 🗆 N	IP □ CITY/S	PA TATE			ZIP	Email				
NYS License # (F	Required)			Te	I				Fax	ı	CDC & AAP recommend annual			
										seasonal influenza vaccination for all children diagnosed with diabetes.				

### ডায়াবেটিস মেডিকেশন অ্যাডমিনিস্ট্রেশন ফর্ম

সেবা প্রদানকারীর ঔষধ প্রদান সংক্রান্ত নির্দেশনার ফর্ম। 2023-24 শিক্ষা বছর অনুগ্রহ করে সকল DMAF 347-396-8932/8945 নম্বরে ফ্যাক্স করুন

# পিতামাতা ও অভিভাবকগণ: পড়ুন, পূরণ করুন, এবং স্বাক্ষর করুন। নিচে স্বাক্ষর দিয়ে আমি নিম্নলিখিত বিষয়গুলো মেনে নিচ্ছি:

- 1. আমি সম্মতি দিচ্ছি যে নার্স/স্কুল ভিত্তিক স্বাস্থ্য সেবা প্রদানকারী (স্কুল বেজড হেলথ্ সেন্টার, SBHC) আমার সন্তানকে প্রেসক্রিপশন ঔষধ দিতে পারবে, এবং নার্স/প্রশিক্ষিত স্টাফ/SBHC প্রদানকারী ব্লাড সুগার পরীক্ষা করতে পারবে, এবং তারা আমার সন্তানের লো ব্লাড সুগারের পরিচর্যা করবে নির্দেশনা অনুযায়ী এবং তাদের দক্ষতার স্তর নির্ধারণ করবে স্বাস্থ্য সেবা প্রদানকারী। চিকিৎসা প্রদান করা হতে পারে স্কুল গ্রাউন্ডে অথবা স্কুল ট্রিপের সময়।
- 2. আমার সন্তানের ঔষধ সংরক্ষণ করার এবং অতঃপর স্কুলে ব্যবহার করার জন্য যদি কোনও সরঞ্জাম প্রয়োজন হয় সেগুলোর জন্যেও অনুমতি দিছি।

#### 3. वामि तूबि त्यः

- আমি অবশ্যই স্কুল নার্সকে/SBHC প্রদানকারীকে আমার সন্তানের ঔষধ, স্ন্যাকস, সরঞ্জাম (ইকু্যইপমেন্ট), এবং অন্যান্য সামগ্রী প্রদান করবো এবং অবশ্যই যেগুলো নার্সের শেষ হয়ে গেছে ওগুলো, যেমন ঔষধ, সরঞ্জাম এবং অন্যান্য সামগ্রী পুনরায় সরবরাহ করতে হবে। অফিস অভ স্কুল হেলথ্ (OSH) সেফটি ল্যানসেট এবং অন্যান্য সেফটি নিডল ডিভাইস ও সাপ্পাই আছে ওগুলো আমার সন্তানের ব্লাড সুগার লেভেল পরিমাপ করতে এবং ইনস্যুলিন দিতে পরামর্শ দেয়।
- আমি যেসব প্রেসক্রিপশন এবং "ওভার-দ্যা-কাউন্টার" (কাউন্টার থেকে কেনা) ঔষধ স্কুলে দিব, সেগুলো অবশ্যই নতুন, মুখবন্ধ, এবং আসল (অরিজিন্যাল) বোতল বা বাক্সের মধ্যে থাকতে হবে। স্কুল দিবসে ব্যবহার করার জন্য আমি বর্তমানে গ্রহণ করছে, মেয়াদোন্তীর্ণ হয়ে যায়নি এমন ঔষধ স্কুলে প্রদান করবো।
  - পেসক্রিপশন ঔষধের বোতল অথবা বাক্সের উপর অবশ্যই ফার্মাসির **আসল** লেবেল থাকতে হবে। লেবেলে যা যা অন্তর্ভুক্ত থাকতে হবে: 1) আমার সন্তানের নাম, 2) ফার্মাসির নাম ও ফোন নম্বর, 3) আমার সন্তানের স্বাস্থ্য সেবা প্রদানকারীর নাম, 4) তারিখ, 5) রিফিল সংখ্যা, 6) ঔষধের নাম, 7) ডোজ, 8) ঔষধ সেবনের সময়, 9) ঔষধ কীভাবে সেবন করতে হবে এবং 10) অন্য সব নির্দেশনা।
- আমার সন্তানের ঔষধে অথবা স্বাস্থ্য সেবা প্রদানকারীর নির্দেশনায় কোনও পরিবর্তন হলে স্কুল নার্সকে/পরিষেবা প্রদানকারী SBHC-কে অবশ্যই **অতিসত্বর** জানাতে হবে।
- OSH এবং এর এজেন্টরা, যারা আমার সন্তানকে উপরোক্ত স্বাস্থ্য পরিষেবা(সমূহ) প্রদান করেন, তারা এই ফর্মের তথ্যের সঠিকতার উপর নির্ভর করেন।
- এই মেডিকেশন অ্যাডমিনিস্ট্রেশন ফর্ম (MAF)-টি স্বাক্ষর করার মাধ্যমে, OSH-কে ডায়ারেটিস সংক্রান্ত স্বাস্থ্য পরিষেবা প্রদানের অনুমতি দিচ্ছি। এই পরিষেবাগুলোর মধ্যে থাকতে পারে, কিন্তু এর মধ্যে সীমাবদ্ধ নয়, OSH-এর স্বাস্থ্য পরিষেবা প্রদানকারী অথবা নার্স দ্বারা ক্লিনিক্যাল মূল্যায়ন অথবা শারীরিক পরীক্ষা (ফিজিক্যাল এক্সাম)।
- আমার সন্তানের শিক্ষা বছরের শেষে, এতে গ্রীষ্মকালীন সেশন অন্তর্ভুক্ত হতে পারে, অথবা যখন আমি স্কুল নার্সকে/পরিষেবা প্রদানকারী SBHC-কে একটি নতুন MAF জমা দিব (যেটা আগে হবে), তখন এই MAF-টিতে যে ঔষধ সেবনের নির্দেশনা দেয়া আছে তা বাতিল হয়ে যাবে। যখন ঔষধ সেবনের নির্দেশনা মেয়াদোত্তীর্ণ (এক্সপায়ার) হয়ে যাবে, আমি তখন আমার সন্তানের স্কুল নার্সকে/পরিষেবা প্রদানকারী SBHC-কে স্বাস্থ্য সেবা প্রদানকারীর দ্বারা পূরণকৃত নতুন একটি MAF অবশ্যই প্রদান করবো।
- OSH এবং ডিপার্টমেন্ট অভ এডুকেশন (DOE) আমার সন্তান নিরাপদে নিজের ব্লাড সুগার পরীক্ষা করতে পারে তা নিশ্চিত করবে।
- আমার অনুমতি এবং এই ফর্মে ডায়াবেটিস জনিত সেবার অনুরোধ যেভাবে বর্ণিত আছে এই ফর্মটি তার প্রতিনিধিত্ব করে। এটা OSH-এর কাছে অনুরোধক্ত সেবাগুলো প্রদানের কোনও চুক্তি নয়। যদি OSH এই পরিষেবাগুলো প্রদান করার সিদ্ধান্ত নেয়, তবে আমার সন্তানের হয়তো সেকশন 504 অ্যাকোমোডেশন প্ল্যান (বিশেষ সুবিধার পরিকল্পনা) প্রয়োজন হতে পারে। এই প্ল্যানটি (পরিকল্পনা) স্কুল পূরণ করবে।
- আমার সন্তানকে সেবা এবং চিকিৎসা প্রদানের উদ্দেশ্যে, OSH প্রয়োজন মনে করলে আমার সন্তানের শারীরিক অবস্থা, ঔষধ অথবা চিকিৎসা সম্পর্কিত অন্যান্য তথ্য সংগ্রহ করতে পারে। যেসব হেলথ কেয়ার প্র্যাকটিশনার (স্বাস্থ্য সেবা প্রদানকারী), নার্স, অথবা ফার্মাসিস্ট আমার সন্তানকে স্বাস্থ্য সেবা প্রদান করেছেন, তাদের কাছ থেকে এসব তথ্য OSH সংগ্রহ করতে পারে।

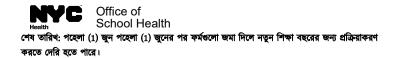
## ভায়াবেটিস মেডিকেশন অ্যাডমিনিস্ট্রেশন ফর্ম (DMAF) সংক্রান্ত প্রশ্লাবলীর জন্য OSH প্যারেন্ট হটলাইন: 718-786-4933

## নিজে ঔষধ সেবনের জন্য (শুধুমাত্র স্বনির্ভর শিক্ষার্থীবৃন্দ)

আমি প্রত্যয়ন/নিশ্চিত করছি যে আমার সন্তান নিজে ঔষধ সেবনে পুরোপুরি প্রশিক্ষিত এবং নিজেই তার ঔষধ নেবে। এই ফর্মের নির্দেশনা অনুযায়ী, আমার সন্তানকে স্কুলে ঔষধ বহন করার,
সংরক্ষণ করার এবং নিজে ঔষধ সেবন করার সম্মতি দিচ্ছি। আমার সন্তানকে উপরে যেভাবে বর্ণিত হয়েছে সেই অনুযায়ী এই ঔষধ বোতল অথবা বক্সে প্রদান করার জন্য আমি দায়বদ্ধ। আমার
সন্তানের ঔষধ ব্যবহারের প্রতি, এবং এই ঔষধ স্কুলে ব্যবহার করার ফলে যে প্রভাব পড়তে পারে, সে ব্যাপারে লক্ষ্য রাখতে আমি দায়বদ্ধ। আমার সন্তান ঔষধ বহন করতে পারবে এবং নিজে
ঔষধ সেবন করতে পারবে কিনা তা স্কুল নার্স অথবা SBHC প্রদানকারীগণ নিশ্চিত করবেন। আমি স্কুলে স্পষ্টভাবে লেবেল করা বাক্স অথবা বোতলে "বাড়তি" (ব্যাক আপ) ঔষধ দিতে সম্মত।
 যদি আমার সন্তান সাময়িকভাবে ঔষধ বহন করতে অথবা নিজে ঔষধ সেবন করতে অক্ষম হয় তবে স্কুল নার্স অথবা প্রশিক্ষণপ্রাপ্ত স্কুল কর্মীগণ তাকে ঔষধ প্রদান করার অনুমতি দিচ্ছি।

### দ্রষ্টব্য: ভালো হয় যদি, যেদিন স্কুল ট্রিপ হবে অথবা অফ-সাইট স্কুল কর্মকাণ্ড হবে সেদিন আপনি আপনার সন্তানের ঔষধ এবং সরঞ্জাম (ইক্যুইপমেন্ট) পাঠিয়ে দেন।

শিক্ষার্থী শেষ নাম আদ্যাক্ষর	প্র	থম নাম		মধ্যনামের	জন্মতারিখ			
স্কুলের ATSDBN/নাম:				বরো		/ ডিব্রিষ্ট		
পিতামাতা/অভিভাবকের নাম ইংরে	রজি বড় অক্ষরে পিখুন		পার্ট A এবং B-এর জন্য পিতা	মাতা/অভিভাবকের স্বাক্ষর	স্বাক্ষর দেওয়ার তারিখ			
পিতামাতা/অভিভাবকের ঠিকানা				পিতামাতা/অভিভাবকের ইমেই	<b>ल</b>	/ /		
ফোন নম্বর	र्गन नम्दत्र फिर्वाकांगीन त्कान न१			বাড়ির ফোন নং		সেল ফোন নং		
জরুরি অবস্থায় যোগাযোগের বিকল্প নাম			শिক্ষার্থীর সাথে সম্পর্ক		যোগাযোগের ফোন নং			



### ডায়াবেটিস মেডিকেশন অ্যাডমিনিস্ট্রেশন ফর্ম

সেবা প্রদানকারীর ঔষধ প্রদান সংক্রান্ত নির্দেশনার ফর্ম । 2023-24 শিক্ষা বছর অনুগ্রহ করে সকল DMAF 347-396-8932/8945 নম্বরে ফ্যাক্স করুন

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Services provided by:   Nurse/NP  School Based Health Center	☐ OSH Public Health Advisor (for supervised students only)				
Signature and Title (RN OR SMD):					
Date School Notified & Form Sent to DOE Liaison	<i>l</i>				
Revisions as per OSH contact with prescribing health care practitioner  □ Clarified □ Modified					
Notes					