



DORCHESTER SCHOOL DISTRICT TWO 2024-2025 TREATMENT REQUEST FORM



This form should be used for treatments needed during the school day. All medications (including OTC), nutritional supplements/tube feeds, respiratory care such as suctioning or trach care, and all diabetic care **must be submitted on the order forms specific to those treatments** and NOT on this form.

The following is to be completed by a physician/legal prescriber.

Name of Student: _____ DOB: _____ Grade/Section: _____

Diagnosis: _____ ICD-10 Code: _____

Treatment(s) required while in the school setting:

Type of Treatment: _____

Level of Care (**check one only**): By Nurse/Staff With Staff Supervision Independent: Staff does not need to monitor student

Time(s) to be done at school: _____

Supplies needed for treatment: _____

List any potential reactions with appropriate treatment: _____

Special Instructions: _____

Physician/Legal Prescriber

Signature of Physician/Legal Prescriber

Office Phone Number

Office Fax Number

Date

The following is to be completed by a parent/legal guardian.

1. I request that school staff assist my child with the treatment as ordered above by the physician or legal prescriber and hereby release everyone participating in this request from any and all liability associated therewith or stemming therefrom.
2. When the School Nurse is not available, the principal's designee(s) may assist your child with this treatment once properly trained.
3. When ordered by the provider, I request that my child be independently allowed to carry out the treatment prescribed above while at school and certify that my child has been educated on how to independently carry out this treatment and demonstrated understanding.
4. I authorize the School Nurse to contact my child's provider for information concerning this treatment when necessary.

Signature of Parent/Legal Guardian

Date