DORCHESTER SCHOOL DISTRICT TWO
2024-2025 NUTRITIONAL SUPPLEMENT REQUEST FORM

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

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

Name of Nutritional Supplement: _____

Amount: _____ ICD-10 Code: _____

Times to be given at school: _____

Please check and complete those that apply:

- ☐ Oral Nutrition _____
- ☐ Per Pump_____ at a Rate of _____ Flush with _____cc of water
- ☐ Per Gravity Syringe _____ Flush with _____cc of water
- ☐ Deliver _____cc of water daily at _____o'clock
- ☐ Prior to administration of formula gently draw back on the syringe plunger: Yes_____ No_____ N/A_____
- ☐ If aspiration greater than _____cc DO NOT feed. Delay _____minutes, and then repeat aspiration
- ☐ If the aspirate continues to be greater than _____cc hold feeding
- ☐ Additional notes: _____

_____ _____
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, the undersigned, ask that the above nutritional supplement be administered to my child as directed and hereby release everyone participating in this request from any and all liability associated therewith or stemming there from.
2. When the School Nurse is not available, the principal's trained designee(s) may assist your child in taking their nutritional supplement.
3. Parent/legal guardian must bring nutritional supplement(s) in an unopened bottle and is responsible for providing all other supplies needed to carry out these orders.
4. Parents are reminded that school personnel will dispose of items not claimed at the end of the school year.
5. All nutritional supplements will be handled in accordance with the above guidelines through the school nurse or principal's designee.
6. I authorize the School Nurse to contact my child's provider for information concerning my child when necessary.

_____ _____
Signature of Parent/Legal Guardian Date