DORCHESTER SCHOOL DISTRICT TWO
2026-2027 TREATMENT REQUEST FORM

INTERNAL USE ONLY:

- ☐ **Supplies Received/Labeled**
- ☐ **Order Entered into SNAP**
- ☐ **ICD-10/Billable Time**
- ☐ **Order Scanned into SNAP**
- ☐ **Condition Entered**
- ☐ **IHP Created**
- ☐ **EAP Created (if needed)**

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 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: ____
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____

_______________________________________ 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. I understand that additional staff may be trained to assist with the request above.
3. I understand that I am responsible for providing all supplies and equipment necessary for carrying out these orders at school. I understand that the use, replacement, and disposal of all supplies will be done following manufacturer guidelines.
4. 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.
5. I authorize the School Nurse to contact my child's provider for information concerning this treatment when necessary.

____ Signature of Parent/Legal Guardian

____ Date