DORCHESTER SCHOOL DISTRICT TWO NUTRITIONAL SUPPLEMENT REQUEST FORM

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

Name of Student: ____Grade/Section: ______________

Name of tube feeding: ____

Dosage: _________________________________ ICD-10 Code: ______________________________

Times to be given at school: ____

- Per Pump________________ Per Gravity ______________
- 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's hold feeding.
- Flush line with _______cc's water or other flush as written:___________________________

_______________________________________ ____
Physician/Legal Prescriber (Print Name and Title) 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 formula to be administered to my child as directed and here by 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 designees will assist your son/daughter in taking his/her nutritional supplement.
3. Parent/legal guardian must bring the formula in an unopen bottle.
4. Parents are reminded that tube feedings will not be administer at school without a Dorchester School District 2 Nutritional Supplement Request Form completed by a legal prescriber and signed by the parent/or legal guardian.
5. Parents are also reminded that school personnel will dispose of formula not claimed at the end of the school year.
6. All formula will be handled in accordance with the above guidelines through the school nurse or principal's designee.

____ ____
Signature of Parent/Legal Guardian Date