

LOS ANGELES UNIFIED SCHOOL DISTRICT
 Office of the Chief Medical Director
 District Nursing Services

**Parent Consent and Healthcare Provider Authorization for
 EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO INJECTOR at School and School-Sponsored Events**

Student:	DOB:	Grade:
School:	Phone:	Fax:

**PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION. NOTE:
 LAUSD SPECIALIZED PHYSICAL HEALTHCARE PROCEDURE FOR
 EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO INJECTOR IS ATTACHED.**

1. Check one:

- I have reviewed and approved the attached standardized procedure as written.
- I have reviewed and approved the attached standardized procedure as written with the attached modifications.
- I **do not** approve of the standardized procedure. I have attached my alternative procedure and recommendations.

- 2. Specific Allergens that cause anaphylaxis:** _____
- 3. Common signs and symptoms:** _____
- 4. Typical reaction time after exposure:** _____
- 5. Administer these medications after exposure to anaphylactic causing allergens : **Epipen or Epipen Jr. (please circle)****
 Dosage/Time/Frequency: _____
- 6. Other medications to be administered before or after Epipen:** _____
- 7. Special Instructions:** _____

**Authorized Healthcare Provider Authorization for
 EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO-INJECTOR in School Setting**

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare procedures may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide the written authorization. Authorizations may be faxed.

***Authorized Healthcare Provider Name:** _____ **Signature:** _____ **Date:** _____

Phone: _____ **Address:** _____ **City:** _____ **Zip:** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** _____

**Parent Consent for Authorization for
 EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO-INJECTOR in School Setting**

I, the undersigned, the parent/guardian of the above named student, request that the specialized physical healthcare procedure be administered to my child in accordance with state laws and regulations. I will :

1. provide the necessary supplies and equipment;
2. notify the school nurse if there is a change in child's health status, or attending healthcare provider; and
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization;
4. provide new written consent/authorization yearly.

I give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Parent/Guardian (Print Name): _____ **Signature:** _____ **Date:** _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Licensed Nurse Acknowledgement of Complete and Accurate Order

_____	_____	_____	_____
Printed Name of Nurse	Signature	Title (RN, LVN)	Date

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Autorización de los padres para TRATAMIENTO DE EMERGENCIA mediante AUTOINYECTOR de EPINEFRINA para CHOQUE ANAFILÁCTICO en el entorno escolar

Yo, el abajo firmante, padre de familia/tutor (legal) del estudiante cuyo nombre aparece arriba, solicito que se aplique a mi hijo el procedimiento de atención médica especializada en conformidad con las leyes y reglamentos estatales. Me comprometo a:

1. Proporcionar los suministros y equipo necesario;
2. Avisarle a la enfermera escolar si hay un cambio en el estado de salud de mi hijo; o bien al proveedor de atención médica; y
3. Avisarle a la enfermera escolar inmediatamente y proporcionar una nueva autorización/consentimiento en caso de cualquier cambio en la autorización antes citada;
4. Anualmente proporcionar autorización/ consentimiento escrito.

Dar consentimiento a la enfermera escolar para comunicarse con el proveedor de servicios de salud cuando sea necesario.

Padre de familia/tutor (letra de molde): _____ **Firma:** _____ **Fecha:** _____

Teléfono del hogar: _____ **Tel. del trabajo:** _____ **Tel. del celular:** _____

Licensed Nurse Acknowledgement of Complete and Accurate Order

_____	_____	_____	_____
Printed Name of Nurse	Signature	Title (RN, LVN)	Date