LOS ANGELES UNIFIED SCHOOL DISTRICT
Medical Services Division
District Nursing Services Branch

Parent Consent and Healthcare Provider Authorization for
Emergency Treatment of Anaphylaxis: Epinephrine Auto-Injector / Nasal Spray
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 / NASAL SPRAY 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. Specify Name of Medication:

Select Route: Epinephrine Auto-Injector ☐ Epinephrine Nasal Spray ☐ **Dosage**: _____	**Frequency**: As needed for signs and symptoms of anaphylaxis	**Side Effects:**

Special Instructions:_____

Authorized Healthcare Provider Authorization for
EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO-INJECTOR / NASAL SPRAY 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 / NASAL SPRAY 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:**_____ **Cellular:** _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

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

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Special Instructions:_____

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EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO-INJECTOR / NASAL SPRAY in School Setting

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

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

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

Autorización de los padres para
TRATAMIENTO DE EMERGENCIA mediante AUTOINYECTOR de EPINEFRINA / AEROSOL NASAL 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.

Nombre del padre/tutor:_____ **Firma:**_____ **Fecha:** _____

Teléfono de casa:_____ **Teléfono de trabajo:**_____ **Celular:** _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

_____

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