

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

**Parent Consent and Authorized Healthcare Provider Authorization for
MECHANICAL NEBULIZER at School and School-Sponsored Events**

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

**NOTE: STANDARD EMERGENCY CARE PROCEDURE FOR MECHANICAL NEBULIZER IS ATTACHED.
PLEASE REVIEW AND SIGN FORM TO INDICATE AUTHORIZATION.**

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. Time/Frequency to be administered at school _____ and/or

PRN if needed for _____

Special Instructions: _____

Authorized Healthcare Provider Authorization for MECHANICAL NEBULIZER 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 and Management of MECHANICAL NEBULIZER 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 Phone:** _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

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

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

**Parent Consent and Authorized Healthcare Provider Authorization for
MECHANICAL NEBULIZER at School and School-Sponsored Events**

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

**NOTE: STANDARD EMERGENCY CARE PROCEDURE FOR MECHANICAL NEBULIZER IS ATTACHED.
PLEASE REVIEW AND SIGN FORM TO INDICATE AUTHORIZATION.**

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. Time/Frequency to be administered at school _____ and/or
 PRN if needed for _____

3. Special Instructions: _____

Authorized Healthcare Provider Authorization for MECHANICAL NEBULIZER 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** _____

Consentimiento del padre de familia para autorizar el proceso de NEBULIZADOR MECÁNICO 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 Completeness and Meets District Guidelines

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