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

Parent Consent and Authorized Healthcare Provider Authorization for OXYGEN THERAPY and/or PULSE OXIMETRY at School and School-Sponsored Events

Student:	**DOB:**	**Gender:**	**Grade:**
School:	**Phone:**		**Fax:**

Oxygen Therapy Authorization

NOTE: TO BE COMPLETED BY HEALTHCARE PROVIDER.
STANDARD EMERGENCY CARE PROCEDURE FOR OXYGEN THERAPY 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. Dosage prescribed: _____ L/min of oxygen via ____ Nasal cannula _____ Mask ____ Tracheal oxygen adapter

3. Source: _____ Oxygen Tank _____ Oxygen Concentrator _____ Liquid Oxygen

4. Time/Frequency to be administered at school:

- ☐ Continuous Administration
- ☐ PRN for the following symptoms/conditions: _____
- ☐ PRN as per Pulse Oximetry authorization

5. Special Instructions:

_____

_____

_____

NAME: _____ DOB:_____GENDER:_____

Oxygen Therapy Healthcare Provider

Authorized Healthcare Provider Authorization for OXYGEN THERAPY 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:** _____

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

Print the Name of the Supervising Physician_____

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

Oxygen Therapy Parent Consent

Parent Consent for Authorization and Management of OXYGEN THERAPY 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 Phone:_____

NAME: _____ DOB:_____GENDER:_____

Pulse Oximetry Authorization Therapy Authorization

NOTE: STANDARD EMERGENCY CARE PROCEDURE FOR PULSE OXIMETRY IS ATTACHED.
PLEASE REVIEW AND SIGN FORM TO INDICATE AUTHORIZATION.

☐ **PULSE OXIMETER MONITORING NOT REQUIRED AT SCHOOL (*Skip to Healthcare Authorization for Oxygen*)**

☐ **PULSE OXIMETER MONITORING MEDICALLY NECESSARY TO ATTEND SCHOOL**

****If not required, skip to healthcare authorization for Oxygen****

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 alternative procedure and recommendations.

2. Time/Frequency to be administered at school:

☐ Continuous Monitoring

☐ Monitor SpO2% Levels at: TIME (S)_____

☐ Monitor SpO2% Levels for the following signs or symptoms:_____

3. Student's SpO2% Baseline: _____to_____

4. Instructions: If Student's SpO2% is at or below: _____Proceed with the following interventions:

A. _____

B. CALL 911 FOR SpO2% OF _____

C. **CALL 911 FOR ANY EMERGENCIES**

NAME: _____ DOB: _____ GENDER: _____

Pulse Oximetry Healthcare Provider

Authorized Healthcare Provider Authorization for PULSE OXIMETRY 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:** _____

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

Print the Name of the Supervising Physician _____

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

Pulse Oximetry Healthcare Parent Consent

Parent Consent for Authorization and Management of PULSE OXIMETRY 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 Phone: _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

_____

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