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 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: FurnishingNumber:** ___________________________________

Print the Name of the Supervising Physician____

Address: ____**City**___________________________**Zip**_________________

Oxygen Therapy Parent Consent

Consentimiento del padre de familia para autorizar el proceso de TERAPIA DE OXIGENO 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:**_________________________**Date:**___________

Teléfono del hogar:__________________________ **Teléfono del trabajo :**_________________________

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 my 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

Consentimiento del padre de familia para autorizar el proceso de OXIMETRIA DE PULSO 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.

Padre de familia/tutor (letra de molde):__________________________**Firma:**__________________________**Date:**___________

Teléfono del hogar:__________________________ **Teléfono del trabajo :**__________________________

Cellular Phone:__________________________

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

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