



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

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: Furnishing Number: _____

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

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