PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR <u>NEBULIZER TREATMENT</u>

Name of Student: _____ Birth date: _____ Grade/Track: _____

School/District: _____ Teachers Name: _____

Physical condition for which treatment is to be given: _____

California Education Code Section, 49423.5 allows the school nurse to train monitor and supervise non-medical school personnel to assist students who require treatment during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that the treatment stated below be administered to my child in accordance as ordered by the authorized health care provider. I understand that designated non-medical school personnel will administer treatment under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or prescribing authorized health care provider. I give permission for the school nurse to exchange treatment related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the treatment and its possible reactions.

Parent/Guardian Signature:_____ Date: _____

Telephone: (Work) _____ (Home) _____ (Other) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR **<u>NEBULIZER TREATMENT</u>**

Nebulizer Treatment requested during school hours: ( ) **Yes** ( ) **No**
Diagnosis/Reason for Medication:_____
Medication: _____ Dose: _____ Route: _____ Time: _____
Medication:_____ Dose: _____ Route: _____ Time: _____
Time schedule and/or indication:_____
If PRN: Amount of time between doses _____ Maximum number of doses _____ per day.
Precautions, possible untoward reactions, and recommend intervention(s): _____
_____

Nursing practice standards will be used for the above stated treatment UNLESS there are specific modifications or recommendations needed:

( ) a. Implement the treatment using nursing practice standards.
( ) b. Implement the treatment using nursing practice standards along with my modifications.
( ) c. Implement the treatment using nursing practice standards along with my attached recommendations.

Modifications:_____

Authorized Health Care Provider Signature: _____

Telephone: _____

Date of Request: _____

Date to Discontinue Treatment: _____

Office Stamp

SCHOOL USE

Reviewed by:_____ Date:

_____

_____ Date: _____

Revised: 4/05 DR

This request is valid for a maximum of one year.