



LOS ANGELES UNIFIED SCHOOL DISTRICT

Medical Services Division

District Nursing Services Branch

Parent Consent and Healthcare Provider Authorization for
Emergency Treatment of Anaphylaxis: Epinephrine Auto-Injector / Nasal Spray
at School and School-Sponsored Events

Student:		DOB:		Grade:
School:		Phone:		Fax:
PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.				
*NOTE: LAUSD SPECIALIZED PHYSICAL HEALTHCARE PROCEDURE FOR <u>EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO INJECTOR / NASAL SPRAY</u> IS ATTACHED.				
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. Specific Allergens that cause anaphylaxis: _____				
3. Common signs and symptoms: _____				
4. Specify Name of Medication:				
Select Route: Epinephrine Auto-Injector ☐ Epinephrine Nasal Spray ☐ Dosage: _____		Frequency: As needed for signs and symptoms of anaphylaxis		Side Effects:
Special Instructions: _____				
Authorized Healthcare Provider Authorization for <u>EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO-INJECTOR / NASAL SPRAY</u> 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 for <u>EMERGENCY TREATMENT OF ANAPHYLAXIS: EPINEPHRINE AUTO-INJECTOR / NASAL SPRAY</u> 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: _____
Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines				
Printed Name of Nurse _____		Signature _____		Title (LVN, RN) _____ Date _____



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*Authorized Healthcare Provider Name: _____ Signature: _____ Date: _____		
Phone: _____ Address: _____ City: _____ Zip: _____		
*Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number _____		
Autorización de los padres para <u>TRATAMIENTO DE EMERGENCIA mediante AUTOINYECTOR de EPINEFRINA / AEROSOL NASAL para CHOQUE ANAFILÁCTICO</u> 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.		
Nombre del padre/tutor: _____ Firma: _____ Fecha: _____		
Teléfono de casa: _____ Teléfono de trabajo: _____ Celular: _____		
Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines		
Printed Name of Nurse	Signature	Title (LVN, RN) Date