



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

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.

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.

Parent/Guardian Signature: Date:

Telephone: (Work) (Home) (Other)

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR NEBULIZER TREATMENT

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.

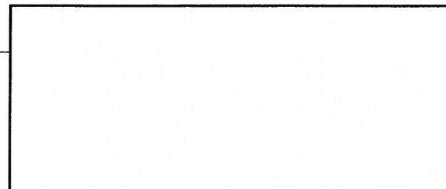
Modifications:

Authorized Health Care Provider Signature:

Telephone:

Date of Request:

Date to Discontinue Treatment:



Office Stamp

SCHOOL USE

Reviewed by:

Date:

Date: