



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.

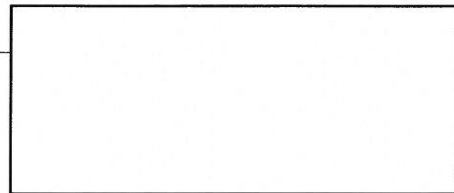
Modifications:

Authorized Health Care Provider Signature:

Telephone:

Date of Request:

Date to Discontinue Treatment:



Office Stamp

SCHOOL USE

Reviewed by:

Date:

Date: