CLARK COUNTY SCHOOL DISTRICT
Health Services Department

LICENSED HEALTH CARE PROVIDER'S SPECIALIZED ORDERS FOR HEALTH SERVICES AT SCHOOL: Nebulizer Treatment

1. Student Name: _____ ID #: _____ Date of Birth: _____
2. Diagnosis: _____
3. Medication:
   Name: _____
   Dose: _____
4. Frequency:
   ☐ As needed every _____ hours for wheezing, coughing, shortness of breath, or _____
   ☐ Routine every _____ hours, until (date) _____
   ☐ Before PE
   ☐ Other: _____
   ☐ If no relief from first treatment within 15 minutes, may give second treatment. Contact parent/guardian to pick up. Student must go home.

Provider Name (Print)	Provider Signature Stamped LHCP Signature is not accepted	Date
Address	Fax #	Phone #

PARENT/GUARDIAN REQUEST FOR HEALTH SERVICES IN SCHOOL

1. This procedure is necessary for my child to attend school and cannot be provided before or after school hours.
2. I request that the treatment be administered in accordance with the above licensed health care provider's orders. I will notify the school if the health status of my child changes, the licensed health care provider changes, or the procedure is changed or canceled.
3. I agree to provide clearly-labeled, functional equipment and supplies. I also agree to provide verbal or written directions for use.
4. The school is authorized to secure emergency medical services for my child whenever the need for such services as deemed necessary.

Notice: Pursuant to NAC 632.220, as a condition of providing care for the purposes related to this form, a registered nurse may need to contact the licensed health care provider or associates regarding the verification of an order given for the care of a patient to ensure that it is appropriate and properly authorized and that there are no documented contraindications in carrying out the order.

Parent/Guardian Name (Print)	Parent/Guardian Signature	Date

Provider & Parent/Guardian Must Complete this Form Yearly.