



LOS ANGELES UNIFIED SCHOOL DISTRICT  
 Medical Services Division  
 District Nursing Services Branch

**Parent Consent and Healthcare Provider Authorization for  
 Nasogastric (NG) Tube: Pump Method Nasogastric (NG) Feeding: Pump Method  
 at School and School Sponsored Events**

<b>Student:</b>	<b>DOB:</b>	<b>Grade:</b>
<b>School:</b>	<b>Phone:</b>	<b>Fax:</b>

PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.

**\*NOTE: LAUSD SPECIALIZED PHYSICAL HEALTHCARE PROCEDURE FOR NASOGASTRIC (NG) FEEDING: PUMP METHOD IS ATTACHED. AUTHORIZED HEALTHCARE PROVIDER TO COMPLETE THE FOLLOWING SECTION (MD, DO, PA, NP)**

**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.

**NG-Tube Size:** \_\_\_\_\_ **Fr** **NG-Tube Length: Number at Nostril:** \_\_\_\_\_ **and/ or Nare to Cap:** \_\_\_\_\_  **pH Testing**

**Times(s) to be administered at school:** \_\_\_\_\_ **ICD 10 Code:** \_\_\_\_\_

**Name of feeding:** \_\_\_\_\_

**Amount:** \_\_\_\_\_ **mL** **Pump Rate:** \_\_\_\_\_ **mL/hr**

- May provide comparable substitute formula provided by pharmacy/parent/guardian
- Parent/guardian prepared feeding/ formula (**Must be labeled:** Student Name, "Parent-prepared feeding," amount, date/time prepared)

**Flush: Before feeding** \_\_\_\_\_ **mL** **After feeding** \_\_\_\_\_ **mL**

**Mode** (Select one)  **Gravity**  **Pump Rate:** \_\_\_\_\_ **mL/hr**  **Push Rate:** \_\_\_\_\_ **ml/min**

**\*Note:** Water flush amounts over 60 mL require a separate authorization form for hydration.

**Venting:** As needed for signs / symptoms: \_\_\_\_\_

**Oral Feeding:**  **No**  **Yes** (if yes, check one):  **Regular diet**  **Special diet required** (must complete [LAUSD Medical Statement to Request Special Meals](#))

**Special Instructions:** \_\_\_\_\_

**Authorized Healthcare Provider Authorization for**

**NASOGASTRIC (NG) FEEDING: PUMP METHOD at School and School-Sponsored Events**

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 services may be performed by a licensed nursing provider (School Nurse or LVN) or by a school physician. 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**

**NASOGASTRIC (NG) FEEDING: PUMP METHOD at School and School-Sponsored Events**

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;
3. Notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization; and
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:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines**

Printed Name of Nurse \_\_\_\_\_ Signature \_\_\_\_\_ Title (RN, LVN) \_\_\_\_\_