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

Parent Consent and Healthcare Provider Authorization for
EMERGENCY TREATMENT OF CHOKING LIFEVAC® DEVICE
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
EMERGENCY TREATMENT OF CHOKING: LIFEVAC® DEVICE FORM 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 attachedmodifications.

☐ I **do not** approve of the standardized procedure. I have attached my alternative procedure and recommendations.

2. PRN if needed for _____

3. Special Instructions: _____

Authorized Healthcare Provider Authorization for EMERGENCY TREATMENT OF CHOKING: LIFEVAC® DEVICE 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: FurnishingNumber** _____

Parent Consent for Authorization for EMERGENCY TREATMENT OF CHOKING: LIFEVAC® DEVICE 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:** _____ **Cell Phone:** _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

_____	_____	_____	_____
Printed Name of Nurse	**Signature**	**Title (RN, LVN)**	**Date**

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Student:	**DOB:**	**Grade:**
School:	**Phone:**	**Fax:**

PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.
NOTE: LAUSD SPECIALIZED PHYSICAL HEALTHCARE PROCEDURE: EMERGENCY TREATMENT OF CHOKING: LIFEVAC® DEVICE FORM 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. PRN if needed for_____

3. Special Instructions:_____

Authorized Healthcare Provider Authorization for EMERGENCY TREATMENT OF CHOKING: LIFEVAC® DEVICE 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** _____

Consentimiento del padre / madre / tutor para autorizar
TRATAMIENTO DE EMERGENCIA POR ASFIXIA: DISPOSITIVO LIFEVAC® en la escuela

Yo, quien firma abajo, padre/madre/tutor del alumno(a) arriba mencionado, solicito que se administre a mi hijo(a) el procedimiento especializado de atención médica física de acuerdo con las leyes y los reglamentos estatales. Yo:

1. proporcionaré los suministros y el equipo necesarios ;
2. notificaré a la enfermera de la escuela si se produce un cambio en el estado de salud del niño/la niña o del profesional médico que le atiende; y
3. notificaré a la enfermera de la escuela inmediatamente y proporcionaré un nuevo consentimiento / autorización por escrito en caso de cualquier cambio en la autorización anterior .
4. proporcionaré anualmente un nuevo consentimiento / autorización por escrito.

Doy mi consentimiento para que la enfermera de la escuela se comunique con el proveedor de atención médica autorizado cuando sea necesario.

Padre / Madre / Tutor (Nombre en letra de molde):_____**Firma:**_____**Fecha:**_____

Teléfono del hogar:_____**Teléfono del trabajo:**_____**Teléfono móvil:** _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guide ines

_____	_____	_____	_____
Printed Name of Nurse	**Signature**	**Title (RN, LVN)**	**Date**

Adapted from Form B, Section 3, *The Green Book: Guidelines for Specialized Physical Healthcare Physical Healthcare Procedures in School Settings (4/11)*