LOS ANGELES UNIFIED SCHOOL DISTRICT
Medical Services Division
District Nursing Services

Parent Consent and Healthcare Provider Authorization for

_____

Student	**DOB:**	**Date:**
School:	**Phone:**	**Fax**

PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.
NOTE: LAUSD STANDARDIZED PROCEDURE FOR _____ ADMINISTRATION IS ATTACHED

1. ☐ I have attached procedure instructions and recommendations.

2. ☐ PRN if needed for _____

3. Special Instructions: _____

_____

_____

_____

Authorized Healthcare Provider Authorization for _____ 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** _____

Parent Consent for Authorization for _____ 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**