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

Parent Consent and Healthcare Provider Authorization for
GASTROSTOMY: TUBE REPLACEMENT 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 FOR
GASTROSTOMY: TUBE REPLACEMENT 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. Gastrostomy tube replacement is performed at school PRN (as needed) for_____

3. Special Instructions: _____

Authorized Healthcare Provider Authorization for GASTROSTOMY: TUBE REPLACEMENT 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 GASTROSTOMY: TUBE REPLACEMENT in School Setting

I, the undersigned, the parent/guardian of the above-named student, request that the specialized physical healthcare procedure, Gastrostomy Tube Replacement, 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**

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

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GASTROSTOMY: TUBE REPLACEMENT 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 FOR GASTROSTOMY TUBE REPLACEMENT 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. Gastrostomy tube replacement is performed at school PRN (as needed) for _____

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Authorized Healthcare Provider Authorization for GASTROSTOMY TUBE REPLACEMENT 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**_____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** _____

Consentimiento del padre de familia para autorizar el proceso de REEMPLAZO DE TUBO GASTROINTESTINAL en el entorno escolar

Yo, el abajo firmante, padre de familia/tutor (legal) del estudiante cuyo nombre aparece arriba, solicito que se aplique a mi hijo el procedimiento de atención médica especializada, reemplazo de tubo gastrointestinal, en conformidad con las leyes y reglamentos estatales. Me comprometo a:

1. Proporcionar los suministros y equipo necesario;
2. Avisarle a la enfermera escolar si hay un cambio en el estado de salud de mi hijo; o bien al proveedor de atenciór médica; y
3. Avisarle a la enfermera escolar inmediatamente y proporcionar una nueva autorización/consentimiento en caso de cualquier cambio en la autorización antes citada.
4. Anualmente proporcionar autorización/ consentimiento escrito.

Dar consentimiento a la enfermera escolar para comunicarse con el proveedor de servicios de salud cuando sea necesario.

Padre de familia/tutor (letra de molde):_____**Firma:**_____**Fecha:**_____

Teléfono del hogar:_____**Tel. del trabajo:**_____**Tel. del celular:** _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

_____	_____	_____	_____
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)*