

LOS ANGELES UNIFIED SCHOOL DISTRICT

Medical Services Division

District Nursing Services Branch

Parent Consent and Healthcare Provider Authorization for

GASTROSTOMY FEEDING: SLOW DRIP METHOD OR PUMP at School and School-Sponsored Events

Student:	DOB:	Grade:
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School:	Phone:	Fax:
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PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.

NOTE: LAUSD SPECIALIZED PHYSICAL HEALTHCARE PROCEDURE

FOR **Gastrostomy Feeding: Slow Drip Method or Pump** 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. Time/Frequency to be performed at school _____

3. Special Instructions:

- Name of feeding: _____ Amount: _____
- Slow drip (gravity) over _____ minutes Pump/rate: _____ cc/hour
- Amount of water flush: before feeding: _____ after feeding: _____
- Oral feedings: No Yes If yes, specify: _____

Authorized Healthcare Provider Authorization for Gastrostomy Feeding: **Slow Drip Method or Pump 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 Gastrostomy Feeding: **Slow Drip Method or Pump 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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Phone: _____ Address: _____ City _____ Zip _____

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

Consentimiento del padre de familia para que se autorice y aplique el proceso de NUTRICIÓN GASTROINTESTINAL: MÉTODO DE SONDAJE O BOMBEO 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 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 atención 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