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

Parent Consent and Authorized Healthcare Provider Authorization for OSTOMY CARE 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 OSTOMY CARE IS ATTACHED.

Please Specify type of ostomy _____

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 administered at school _____ and/or

☐ PRN if needed for _____

3. Special Instructions: _____

Authorized Healthcare Provider Authorization for OSTOMY CARE 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 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 OSTOMY CARE In School Setting

I, the undersigned, the parent/guardian(s) 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 (we) 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,
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
_____	_____	_____	_____

February 2025

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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***Authorized Healthcare Provider Name**_____**Signature**_____**Date**_____

Phone_____**Address**_____**City**_____**Zip** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: FurnishingNumber** _____

Consentimiento del padre de familia para autorizar el proceso de CUIDADOS DE OSTONOMÍA 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 atenciónmédica
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**

February 2025