

LOS ANGELES UNIFIED SCHOOL DISTRICT
Office of the Chief Medical Director
District Nursing Services

**Parent Consent and Authorized Healthcare Provider Authorization for
DIABETES: KETONE TESTING at School and School-Sponsored Events**

Student:	DOB:	Date:
School:	PHONE:	FAX:

NOTE: STANDARD PROCEDURE FOR **DIABETES: KETONE TESTING** IS ATTACHED.
PLEASE REVIEW AND CHECK APPROPRIATE BOX TO INDICATE AUTHORIZATION.

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 LAUSD's standardized procedure. I have attached my alternative procedure and recommendations.

2. PRN (if needed) for _____

3. Special Instructions: _____

Authorized Healthcare Provider Authorization for **DIABETES: KETONE TESTING 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 initial emergency management services 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 or e-mailed.

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

Phone _____ **Address** _____ **City** _____ **Zip** _____

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

Parent Consent for Authorization and Management of **DIABETES: KETONE TESTING in School Setting**

I (we) the undersigned, the parent/guardian(s) of the above-named student, request that the above standardized procedure, be administered to my (our) 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; and
4. provide new written consent/authorization yearly.

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Parent(s)/Guardian(s) Print name _____ **Signature** _____ **Date** _____

Home phone: _____ **Work phone:** _____ **Cell Phone** _____

Licensed Nurse Acknowledgement of Complete and Accurate Order

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