

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

**Parent Consent and Healthcare Provider Authorization for  
OROPHARYNGEAL/NASOPHARYNGEAL SUCTIONING at School and School-Sponsored Events**

|                 |               |               |
|-----------------|---------------|---------------|
| <b>Student:</b> | <b>DOB:</b>   | <b>Grade:</b> |
| <b>School:</b>  | <b>Phone:</b> | <b>Fax:</b>   |

**PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.  
NOTE: LAUSD SPECIALIZED PHYSICAL HEALTHCARE PROCEDURE FOR  
OROPHARYNGEAL/NASOPHARYNGEAL SUCTIONING 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 \_\_\_\_\_

PRN if needed for \_\_\_\_\_

**3. Special Instructions:** \_\_\_\_\_

**Authorized Healthcare Provider Authorization for  
OROPHARYNGEAL/NASOPHARYNGEAL SUCTIONING 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 OROPHARYNGEAL/NASOPHARYNGEAL SUCTIONING 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**

|                              |                  |                        |             |
|------------------------------|------------------|------------------------|-------------|
| _____                        | _____            | _____                  | _____       |
| <b>Printed Name of Nurse</b> | <b>Signature</b> | <b>Title (RN, LVN)</b> | <b>Date</b> |

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- I **do not** approve of the standardized procedure. I have attached my alternative procedure and recommendations.

**2. Time/Frequency to be performed at school \_\_\_\_\_**

PRN if needed for \_\_\_\_\_

**3. Special Instructions: \_\_\_\_\_**

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**\*Authorized Healthcare Provider Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** \_\_\_\_\_

**Consentimiento del padre de familia para autorizar el proceso de SUCCIÓN ORAL/NASAL 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**

|                              |                  |                        |             |
|------------------------------|------------------|------------------------|-------------|
| _____                        | _____            | _____                  | _____       |
| <b>Printed Name of Nurse</b> | <b>Signature</b> | <b>Title (RN, LVN)</b> | <b>Date</b> |