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

Parent Consent and Authorized Healthcare Provider Authorization for
MANAGEMENT OF AUTONOMIC DYSREFLEXIA: EMERGENCY CARE at School and School-Sponsored Events

Student:	**DOB:**		**Grade:**
School:	**Phone:**	**Fax:**	

NOTE: STANDARD EMERGENCY CARE PROCEDURE FOR
MANAGEMENT OF AUTONOMIC DYSREFLEXIA: EMERGENCY CARE IS ATTACHED.
PLEASE REVIEW AND SIGN FORM 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 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
MANAGEMENT OF AUTONOMIC DYSREFLEXIA: EMERGENCY 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 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 and Management of
MANAGEMENT OF AUTONOMIC DYSREFLEXIA: EMERGENCY CARE 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**

February 2023

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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Student:		**DOB:**		**Grade:**
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PLEASE REVIEW AND SIGN FORM 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 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
MANAGEMENT OF AUTONOMIC DYSREFLEXIA: EMERGENCY 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 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** ______________________________

Consentimiento del padre de familia para que se autorice y aplique el proceso de
TRATAMIENTO PARA DISREFLEXIA AUTONÓMICA: ATENCIÓN PARA EMERGENCIAS 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**