

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

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

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

**NOTE: STANDARD PROCEDURE FOR DIABETES: BLOOD GLUCOSE 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: BLOOD GLUCOSE 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: BLOOD GLUCOSE 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
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Authorized Healthcare Provider Name _____ **Signature** _____ **Date** _____

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

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

Consentimiento del padre de familia para autorizar el proceso de PRUEBA DE GLUCOSA EN SANGRE 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 Complete and Accurate Order

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